**Cabenuva Prior Authorization Form**

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| --- | --- |
| **Client name:** Click here to enter text. | |
| **Date of birth:** Click here to enter text. | **ADAP ID#:** Click here to enter text. |

**Is this a  new start, or  continuation of therapy?**

**Cabenuva maintenance dose:  400mg/600mg/monthly or  600mg/900mg bimonthly**

|  |  |  |
| --- | --- | --- |
| Does client have a history of treatment failure? | Yes | No |
| Has client had a detectable viral load in past 6 months? | Yes | No |
| Does client have Chronic Hepatitis B infection?  \*It is recommended to vaccinate clients who are not immune to Hepatitis B. | Yes | No |
| Does client have a history of Depression? | Yes | No |
| Do you have any concern about client’s ability to attend regularly scheduled appointments? | Yes | No |
| Is client on any medications that are contraindicated with Cabenuva (carbamazepine, oxcarbazepine, phenobarbital, phenytoin, rifabutin, rifampin, rifapentine, dexamethasone, St John’s wort)? | Yes | No |
| Is there any evidence of resistance to non-nucleoside reverse transcriptase inhibitors (NNRTIs) or integrase strand transfer inhibitors (INSTIs)? | Yes | No |

Please document mutations here: Click here to enter text.

**\*\*Please attach genotype results and any additional information relevant to this request.**

Provide 3 most recent HIV RNA results:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date:  Click to enter a date. | HIV RNA:  Click here to enter text. | Date:  Click to enter a date. | HIV RNA:  Click here to enter text. | Date:  Click to enter a date. | HIV RNA:  Click here to enter text. |

|  |  |  |
| --- | --- | --- |
| Date:Click here to enter text.To the best of my knowledge, I certify that the above information is accurate and true. | | |
| Prescriber Signature: | | |
| Prescriber Name: Click here to enter text. | NPI: Click here to enter text. | |
| Phone #: Click here to enter text. | | Fax #:Click here to enter text. |

**Please fax completed form to (302) 320-1373 for review.**