Mass General Brigham
Health Plan

# Cabenuva (cabotegravir/rilpivirine)
# Effective 09/01/2021

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| **Plan** | ☐ MassHealth UPPL<br>☒Commercial/Exchange | **Program Type** | ☒ Prior Authorization<br>☒ Quantity Limit<br>☐ Step Therapy |
| **Benefit** | ☐ Pharmacy Benefit<br>☒ Medical Benefit (NLX) | | |
| **Specialty Limitations** | N/A | | |
| **Contact Information** | **Specialty Medications** | | |
| | All Plans | Phone: 866-814-5506 | Fax: 866-249-6155 |
| | **Non-Specialty Medications** | | |
| | MassHealth | Phone: 877-433-7643 | Fax: 866-255-7569 |
| | Commercial | Phone: 800-294-5979 | Fax: 888-836-0730 |
| | Exchange | Phone: 855-582-2022 | Fax: 855-245-2134 |
| | **Medical Specialty Medications (NLX)** | | |
| | All Plans | Phone: 844-345-2803 | Fax: 844-851-0882 |
| **Exceptions** | N/A | | |

**Overview**

Cabenuva (cabotegravir/rilpivirine) is indicated for the treatment of HIV-1 infection in adults to replace the current antiretroviral regimen in those who are virologically suppressed (HIV-1 RNA <50 copies/mL) on a stable antiretroviral regimen with no history of treatment failure and with no known or suspected resistance to either cabotegravir or rilpivirine.

**Coverage Guidelines**

Authorization may be granted for members new to the plan who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance programs.

**OR**

Authorization may be granted for members when ALL the following criteria are met, and documentation is provided:

**Cabenuva®** (cabotegravir/rilpivirine)

1. The member has a diagnosis of HIV-1 infection
2. Member is ≥12 years of age
3. Member has no history of treatment failure with antiretroviral drugs
4. Member is virologically suppressed (HIV-1 RNA < 50 copies/mL) on a stable antiretroviral regimen for at least three months (confirm using claims history and laboratory data)
5. Oral lead-in treatment with Vocabria® (cabotegravir) and Edurant® (rilpivirine) will be administered prior to administration of Cabenuva® (cabotegravir/rilpivirine)
6. Appropriate dosing
7. Requested quantity is one kit/month (i.e., ≤ 6 mL/month)

**Continuation of Therapy**

Reauthorization may be granted when prescriber documents a positive response to therapy.

**Limitations**

1. Initial approvals and reauthorizations will be for 12 months.
2. The following quantity limits apply:

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| Cabenuva | 1 kit per month |

**References**


1. Cabenuva (cabotegravir and rilpivirine) [prescribing information]. Triangle Park, NC: GlaxoSmithKline Research; April 2022.


**Review History**

07/21/2021 – Created and Reviewed July P&T. Effective 09/01/2021.
09/21/2022 - Reviewed P&T; updated age requirement for pediatrics; references updated.