Paying for Long Acting Injectables (LAI) for HIV and PrEP

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Agenda

- Insurance coverage (Med-cal, Medicare, ADAP, Healthy SF)
  - Billing as a pharmacy benefit means a retail pharmacy will bill insurance and provide the medication
- Patient Assistance Programs
- Drug Aquisition

Medi-cal Formulary

https://medi-calrx.dhcs.ca.gov/home/cdl

Medi-Cal Rx Contract Drugs List

Effective 10/01/2023

Drug Name	Dosage	Strength/ Package Size	Billing Unit	UM Type	Code I
Cabotegravir	Extended-release intramuscular injection kit	600 mg/3 ml	ml		
Cabotegravir/ Rilpivirine *	Injection Kit	400 mg/600 mg 600 mg/900 mg	ea ea	LR	* Restricted to NDC labeler code 49702.

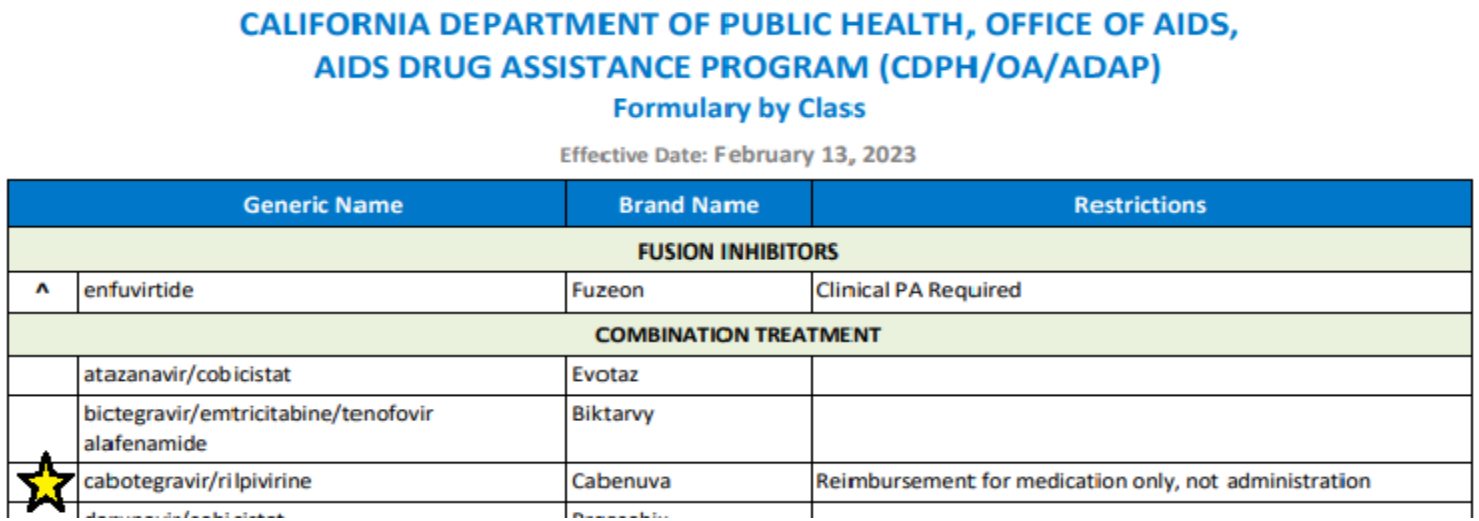
- Both Apretude (cabotegravir) and Cabenuva (cabotegravir/rilpivirine) are covered as a pharmacy benefit

Medicare Coverage and Copays

- Most Medicare plans cover Cabenuva, if not can be approved by prior authorization request
- Apretude will require a prior authorization for Medicare
- The easiest way to submit a prior authorization request is online (i.e., covermymeds.com)
- ICD-10 codes: HIV **B20, Z21**
- PrEP **Z20.2, Z20.6, Z11.3, Z11.4, Z71.7, Z79.899**
- Most low-income subsidized Medicare part d plans have small copays that may go down to zero after the first few months of the year once the deductible is met
- Copay assistance for Medicare is also available through foundations such as Good Days Foundation (≤500% FPL)
- Manufacturer copays cards cannot be used for Medicare copays

ADAP and Healthy San Francisco

https://cdph.magellanrx.com/cms/cdph/static-assets/documents/formulary-and-documents/CDPH_Formulary.pdf



CALIFORNIA DEPARTMENT OF PUBLIC HEALTH, OFFICE OF AIDS,
AIDS DRUG ASSISTANCE PROGRAM (CDPH/OA/ADAP)
Formulary by Class

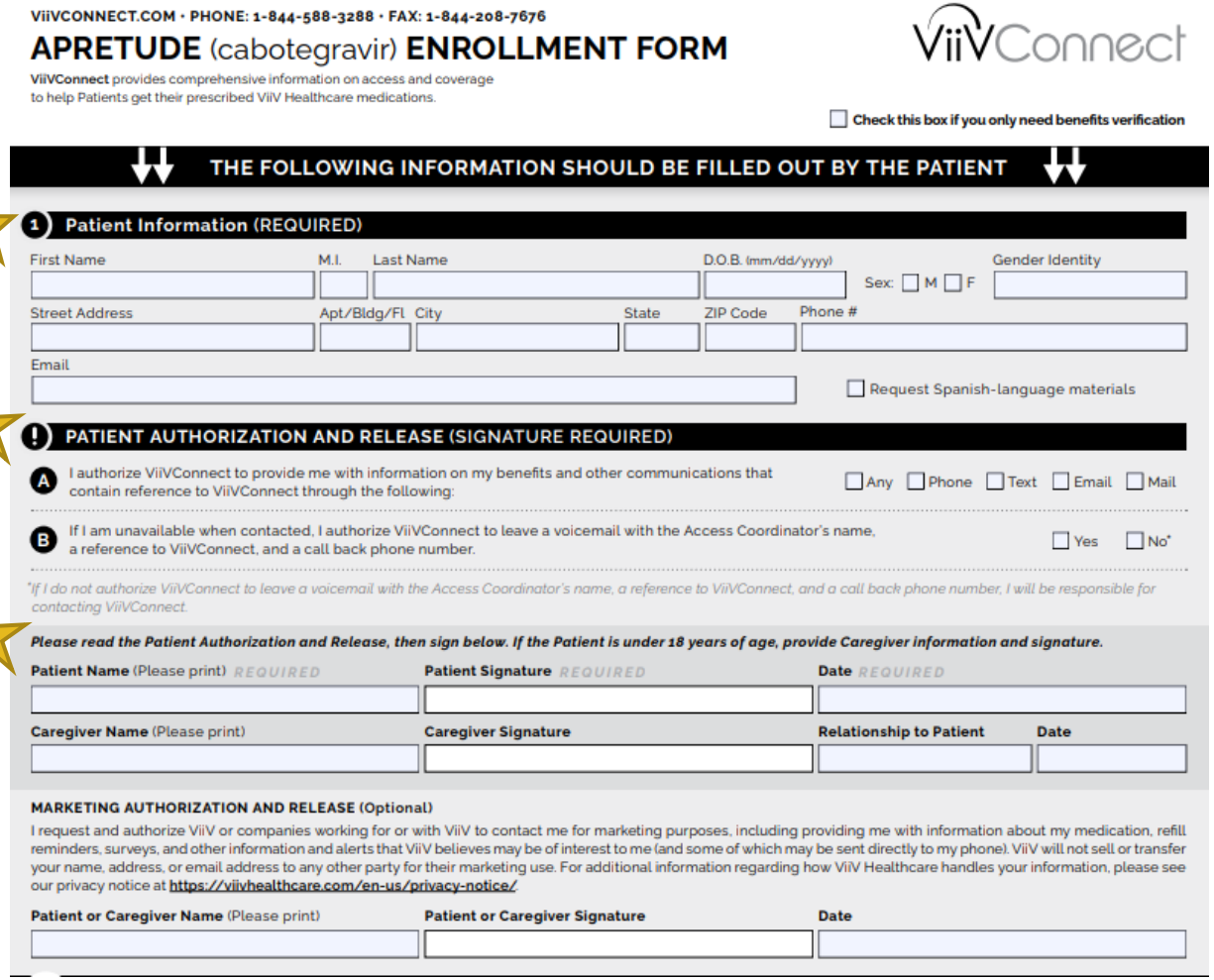
Effective Date: February 13, 2023

	Generic Name	Brand Name	Restrictions
	FUSION INHIBITORS		
^	enfuvirtide	Fuzeon	Clinical PA Required
	COMBINATION TREATMENT		
	atazanavir/cobicistat	Evotaz	
	bictegravir/emtricitabine/tenofovir alafenamide	Biktarvy	
★	cabotegravir/rilpivirine	Cabenuva	Reimbursement for medication only, not administration

- Cabenuva is covered by ADAP (patients renew coverage every 12 months on birthday)
- Healthy San Francisco covers provider visits and labs (renewed annually)
- For patients with Healthy San Francisco, Apretude can be accessed through the manufacturer's patient assistance program

Patient Assistance Program (PAP) Application for Apretude

Submit via fax or online
www.viivconnectportal.com



ViiVCONNECT.COM · PHONE: 1-844-588-3288 · FAX: 1-844-208-7676

APRETUDE (cabotegravir) **ENROLLMENT FORM**

ViiVConnect provides comprehensive information on access and coverage to help Patients get their prescribed ViiV Healthcare medications.

ViiVConnect

☐ Check this box if you only need benefits verification

THE FOLLOWING INFORMATION SHOULD BE FILLED OUT BY THE PATIENT

1 Patient Information (REQUIRED)

First Name | M.I. | Last Name | D.O.B. (mm/dd/yyyy) | Sex: ☐ M ☐ F | Gender Identity

Street Address | Apt/Bldg/Fl | City | State | ZIP Code | Phone #

Email

☐ Request Spanish-language materials

! PATIENT AUTHORIZATION AND RELEASE (SIGNATURE REQUIRED)

A I authorize ViiVConnect to provide me with information on my benefits and other communications that contain reference to ViiVConnect through the following: ☐ Any ☐ Phone ☐ Text ☐ Email ☐ Mail

B If I am unavailable when contacted, I authorize ViiVConnect to leave a voicemail with the Access Coordinator's name, a reference to ViiVConnect, and a call back phone number. ☐ Yes ☐ No*

*If I do not authorize ViiVConnect to leave a voicemail with the Access Coordinator's name, a reference to ViiVConnect, and a call back phone number, I will be responsible for contacting ViiVConnect.

Please read the Patient Authorization and Release, then sign below. If the Patient is under 18 years of age, provide Caregiver information and signature.

Patient Name (Please print) REQUIRED | **Patient Signature** REQUIRED | **Date** REQUIRED

Caregiver Name (Please print) | **Caregiver Signature** | **Relationship to Patient** | **Date**

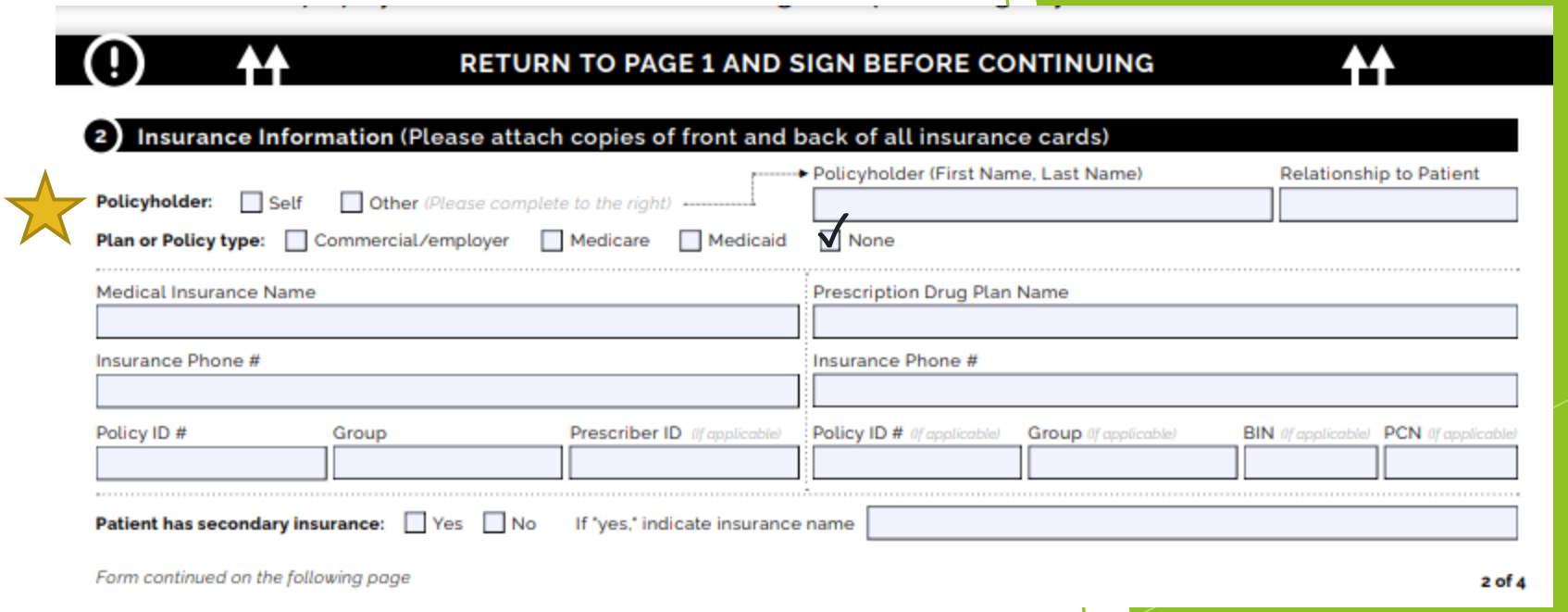
MARKETING AUTHORIZATION AND RELEASE (Optional)

I request and authorize ViiV or companies working for or with ViiV to contact me for marketing purposes, including providing me with information about my medication, refill reminders, surveys, and other information and alerts that ViiV believes may be of interest to me (and some of which may be sent directly to my phone). ViiV will not sell or transfer your name, address, or email address to any other party for their marketing use. For additional information regarding how ViiV Healthcare handles your information, please see our privacy notice at https://viivhealthcare.com/en-us/privacy-notice/

Patient or Caregiver Name (Please print) | **Patient or Caregiver Signature** | **Date**

https://www.viivconnect.com/content/dam/cf-viiv/viivconnect/master/pdf/APRETUDE_English_Enrollment_Form.pdf

Healthy San Francisco is a health access plan not insurance so you can indicate “None” in the policy type section



RETURN TO PAGE 1 AND SIGN BEFORE CONTINUING

2 Insurance Information (Please attach copies of front and back of all insurance cards)

Policyholder: ☐ Self ☐ Other *(Please complete to the right)* — Policyholder (First Name, Last Name) | Relationship to Patient

Plan or Policy type: ☐ Commercial/employer ☐ Medicare ☐ Medicaid ☑ None

Medical Insurance Name	Prescription Drug Plan Name
Insurance Phone #	Insurance Phone #
Policy ID # / Group / Prescriber ID *(if applicable)*	Policy ID # *(if applicable)* / Group *(if applicable)* / BIN *(if applicable)* / PCN *(if applicable)*

Patient has secondary insurance: ☐ Yes ☐ No If "yes," indicate insurance name

Form continued on the following page

2 of 4

3 Injectable Prescription Information

This section of the form is intended as an optional way to prescribe. If your state restricts the use of this form to prescribe, or if this form does not meet your requirements to prescribe, please attach a prescription to this form. Prescribers may need to submit an electronic prescription to the specialty pharmacy.

Please check all that apply:

Prescription/Schedule	Medication	Quantity	Refills	Directions
☐ APRETUDE 600-mg kit	600-mg single-dose vial of cabotegravir	1 dosing kit	1 refill	**Month 1 & Month 2:** 1 injection intramuscularly
☐ APRETUDE 600-mg kit	600-mg single-dose vial of cabotegravir	1 dosing kit	☐ **PRN refills for 1 year** or **# of refills** ____	**Month 4+:** 1 injection intramuscularly, every 2 months

Diagnosis Code: ICD-10 Code

4 OPTIONAL Oral Prescription Information (Not required to start APRETUDE)

Only complete this section if your Patient will be taking the optional oral lead-in to assess tolerability. If your state restricts the use of this form to prescribe, or if this form does not meet your requirements to prescribe, please attach a prescription to this form. Prescribers may need to submit an electronic prescription to the specialty pharmacy.

Prescription/Schedule	Medication	Quantity	Refills	Directions
☐ **Oral Lead-in** *(Dispensed only by TheraCom)*	cabotegravir 30-mg tablet	30 tablets	None	Take 1 tablet by mouth daily

Ship oral medications to: ☐ Prescriber's Office ☐ Patient's Home Address ☐ Other *(Please complete below)* ▾

▸ Street Address | City | State | ZIP Code

5 Prescriber Information (REQUIRED)

First Name | Last Name | Practice Name | Office Contact Name

Phone # | Fax # | Street Address | City | State | ZIP Code

Prescriber Tax ID | Prescriber State License # | Prescriber Email Address | Prescriber NPI | Group NPI | Site Tax ID

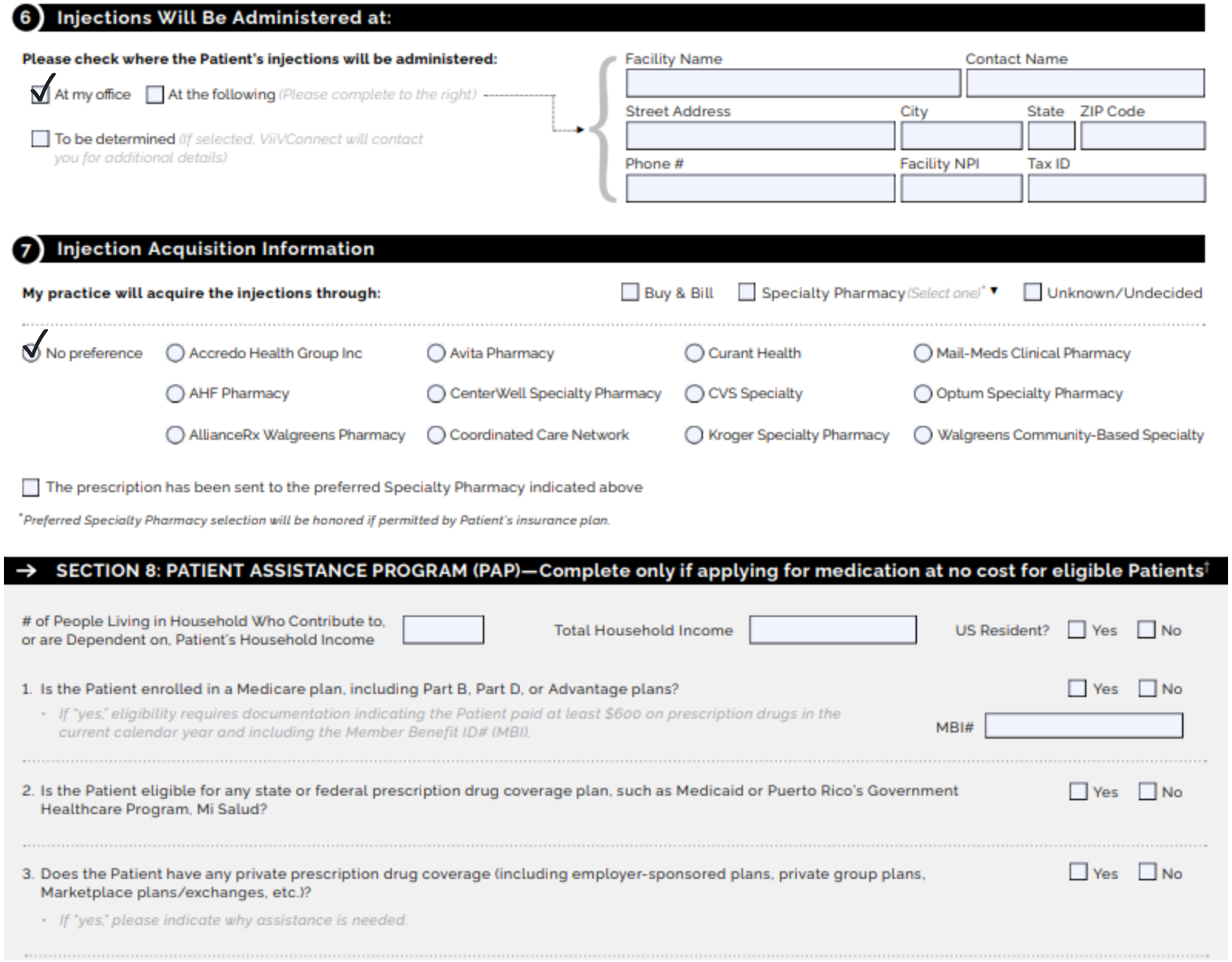
! Prescriber Declaration (REQUIRED)

By signing below, I certify that the information I have provided in this Enrollment Form is complete and accurate to the best of my knowledge.

Prescriber Signature *(Dispense as written)* OR **Prescriber Signature** *(Substitution permitted)* **Date**

Supervising/Collaborating MD Name *(Please print, where required)* **Collaborating Physician NPI** *(Please print, where required)*

- No need to send in separate prescription for the injection and oral lead-in (OLI)
- Use best follow up phone number



6 Injections Will Be Administered at:

Please check where the Patient's injections will be administered:

☑ At my office ☐ At the following *(Please complete to the right)*

☐ To be determined *(If selected, ViiVConnect will contact you for additional details)*

Facility Name | Contact Name

Street Address | City | State | ZIP Code

Phone # | Facility NPI | Tax ID

7 Injection Acquisition Information

My practice will acquire the injections through: ☐ Buy & Bill ☐ Specialty Pharmacy *(Select one)** ▼ ☐ Unknown/Undecided

☑ No preference ○ Accredo Health Group Inc ○ Avita Pharmacy ○ Curant Health ○ Mail-Meds Clinical Pharmacy

○ AHF Pharmacy ○ CenterWell Specialty Pharmacy ○ CVS Specialty ○ Optum Specialty Pharmacy

○ AllianceRx Walgreens Pharmacy ○ Coordinated Care Network ○ Kroger Specialty Pharmacy ○ Walgreens Community-Based Specialty

☐ The prescription has been sent to the preferred Specialty Pharmacy indicated above

**Preferred Specialty Pharmacy selection will be honored if permitted by Patient's insurance plan.*

→ SECTION 8: PATIENT ASSISTANCE PROGRAM (PAP)—Complete only if applying for medication at no cost for eligible Patients†

of People Living in Household Who Contribute to, or are Dependent on, Patient's Household Income | Total Household Income | US Resident? ☐ Yes ☐ No

1. Is the Patient enrolled in a Medicare plan, including Part B, Part D, or Advantage plans? ☐ Yes ☐ No
   - *If "yes," eligibility requires documentation indicating the Patient paid at least $600 on prescription drugs in the current calendar year and including the Member Benefit ID# (MBI).*

   MBI#

2. Is the Patient eligible for any state or federal prescription drug coverage plan, such as Medicaid or Puerto Rico's Government Healthcare Program, Mi Salud? ☐ Yes ☐ No

3. Does the Patient have any private prescription drug coverage (including employer-sponsored plans, private group plans, Marketplace plans/exchanges, etc.)? ☐ Yes ☐ No
   - *If "yes," please indicate why assistance is needed.*

- When using PAP the medication is only filled by Specialty Walgreens
- Provide proof of income or an attestation letter

Drug Acquisition for Oral Lead-in

- **Apretude oral lead-in** cabotegravir known as Vocabria (brand name) is only available through TheraCom pharmacy
- **Cabenuva oral lead-in** TheraCom will provide both Vocabria (cabotegravir) and Edurant (rilpivirine) tablets and can be sent to patient or clinic
- **Locate** in e-Prescribing systems, including SureScripts
  TheraCom 345 International Blvd Ste 200, Brooks, KY 40109.
  Phone: 1-844-276-6299 Fax: 1-833-904-1881
- In the pharmacy notes section of prescription can add "**Opt out of ViiV services, oral lead in only. Deliver to _____**"
- Fax patient med list and allergy information

Drug Acquisition for LAI

- LAI ART can be acquired through specialty pharmacies and delivered to clinic

◯ Accredo Health Group Inc	◯ Avita Pharmacy	◯ Curant Health	◯ Mail-Meds Clinical Pharmacy
◯ AHF Pharmacy	◯ CenterWell Specialty Pharmacy	◯ CVS Specialty	◯ Optum Specialty Pharmacy
◯ AllianceRx Walgreens Pharmacy	◯ Coordinated Care Network	◯ Kroger Specialty Pharmacy	◯ Walgreens Community-Based Specialty

- Utilizing community specialty pharmacies may help facilitate access and avoid delays
- Specialty pharmacies will manage refills and deliver to clinic
- Identify at least 2 pharmacies your site can use in case of any issues

Thank you

Any questions feel free to reach out

Email: francis.mayorga-munoz@ucsf.edu