TEXAS HIV MEDICATION PROGRAM (THMP)
LONG-ACTING INJECTABLE (LAI) MEDICAL CERTIFICATION FORM: CABENUVA
FAX to (512) 989-4003

TEXAS Health and Human Services
Texas Department of State Health Services

PHYSICIAN MUST COMPLETE THE INFORMATION BELOW

Patient TakeChargeTexas (TCT) ID number (if known) _____

The information on this form is necessary to determine the patient's eligibility for program-supplied, HIV-related injectable therapy as prescribed by you. The Department of State Health Services (DSHS) will keep the information on this form strictly confidential. DSHS can only release personal identifying information with patient authorization.

PATIENT INFORMATION

Full Name: _____

Mailing Address: _____ Apt. # _____

City, State, Zip: _____

Phone # _____ Date of Birth: _____ Social Security Number: _____

The patient, _____, understands there are limited slots available, and the LAI is available on a first-come, first-served basis based on THMP eligibility guidelines and the prioritization outlined below.

a) Clients eligible for the Texas Insurance Assistance Program-PLUS (TIAP-PLUS) and are waiting for the open enrollment period. If funds are not exhausted in item (a), DSHS shall prioritize clients in the following order based on available funding:
b) Clients who are eligible for TIAP-PLUS but do not enroll to maintain continuity of care with their local provider; and
c) Other clients eligible for the AIDS Drug Assistance Program (ADAP).

Required: Check the one statement below that best fits the patient's current program status:

☐ **The patient is a THMP client eligible for TIAP-PLUS who is waiting for the open enrollment period.**

☐ **The patient is a THMP client who is eligible for TIAP-PLUS but is not interested in enrolling to maintain continuity of care with a current medical provider. If this statement is checked,** please explain why staying with the current provider helps the client keep the same care, and why the client does not plan to enroll in TIAP-PLUS:

_____
_____
_____
_____

☐ **The patient is a THMP client currently on ADAP who is not interested in or is not eligible for TIAP-PLUS.**

***** This form is a supplement to the standard THMP Medical Certification Form.**
You should only submit this form if you are requesting LAI for your patient. ***

I hereby certify that this patient has been diagnosed with HIV, and I am reporting the following viral load and CD4 count:

Plasma RNA Viral Load: **copies/ml**	Test Date*(mm/dd/yyyy):		**Current CD4 Count:**	Test Date*(mm/dd/yyyy):

*Note: the test date must be within the last 6 months from the signed date below.

PRESCRIBED LAI: ☐ **CABENUVA (cabotegravir/rilpivirine):**

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☐ **New** ☐ **Continuing Therapy** ☐ **Restart Therapy** ☐ **Unknown**

Complete as much information as possible for the questions below. If any information is not known, write "unknown."

Provider secured administration (injection) services at the following facility: _____.

The following source fund will fund this treatment: _____.

DSHS will send LAI to the following THMP participating pharmacy or secondary site: _____.

**** Clients requesting LAI therapy must be assigned to an approved pharmacy or medical facility designated as a secondary site. If the desired facility is not already part of the THMP Participating Pharmacy network, the facility will need to apply via this form: dshs.texas.gov/sites/default/files/hivstd/meds/files/ParticipatingPharmacyRequest.pdf.**

By signing this form, I certify that the following is true:

1. I have or will prescribe LAI: ☐ CABENUVA to the patient named above.
2. The patient is virally suppressed as indicated in the viral load information above.
3. DSHS informed the patient about the location that will administer the LAI or the patient requested help securing an appropriate location.
4. I attest this patient does not have any contraindications to the prescribed medication and is not taking a medication that is contraindicated with the prescribed medication.
5. I attest this patient is competent and willing to be treated and adhere to treatment guidelines.
6. I agree to maintain an appropriate treatment plan for this patient.
7. If this patient is currently receiving LAI: ☐ CABENUVA through other services such as the Pharmacy Assistance Program (PAP) and understands that once THMP approves them for the LAI, then the client will discontinue the LAI services from the respective PAP.
8. The client understands they must maintain THMP eligibility and complete the required twice a year recertification.

To assess the effectiveness of this medication, THMP must receive follow-up data and documentation on enrolled patients, including confirmation of administration of this medication. Please provide contact information for your office so we may follow up on treatment progress periodically. Please designate a contact person who will be available to respond to THMP inquiries. THMP must ensure information is correct for clients to remain in the LAI Pilot Program.

Contact information:

Name: _____

Title: _____

Phone: _____ **Email:** _____

PHYSICIAN SIGNATURE: _____ TX MD/DO LICENSE #: _____

PRINTED NAME OF PHYSICIAN: _____

OFFICE ADDRESS: _____

PHONE: _____ DATE _____