HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM
CABENUVA® & VOCABRIA®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested:) ☐ Cabenuva® (Cabotegravir/rilpivirine), ☐ Vocabria® (cabotegravir)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the request made by, or in consultation with, an infectious disease specialist?	☐	☐	
2. Does documentation show the member is HIV (human immunodeficiency) positive?	☐	☐	**Please provide documentation**
3. Does documentation show a current HIV viral load <50 copies/mL?	☐	☐	**Please provide documentation**
4. Has the member been stable on an antiretroviral regimen for at least the past 12 months?	☐	☐	**Please provide documentation**
5. Does documentation show a history of treatment failure?	☐	☐	**Please provide documentation**
6. Is there known or suspected virologic resistance to cabotegravir or rilpivirine?	☐	☐	**Please provide documentation**
7. Does documentation show that the member has the ability and willingness to visit the clinic to receive injection?	☐	☐	**Please provide documentation**
8. Does the member have an active hepatitis B virus (HBV) infection?	☐	☐	**Please provide documentation**
9. Has the member tried and failed all appropriate preferred HIV regimens?	☐	☐	**Please provide documentation**
10. Does documentation show the member has one of the following: • Severe gastrointestinal issues that likely limits absorption or tolerance of oral medications	☐	☐	**Please provide documentation**

• Social circumstances or mental capacity issues that make compliance with an oral antiretroviral regimen unlikely?			
11. Is the member pregnant or planning to become pregnant?	☐	☐	
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

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Policy: PHARM-CHIP-119
Origination Date: 07/01/2024
Reviewed/Revised Date: 11/13/2024
Next Review Date: 11/13/2025
Current Effective Date: 12/01/2024

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