

HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM CABENUVA® & VOCABRIA®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U 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:		
<p><i>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.</i></p> <p>Product being requested:) <input type="checkbox"/> Cabenuva® (Cabotegravir/rilpivirine), <input type="checkbox"/> Vocabria® (cabotegravir)</p> <p>Dosing/Frequency: _____</p>		

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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation show the member is HIV (human immunodeficiency) positive?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Does documentation show a current HIV viral load <50 copies/mL?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Has the member been stable on an antiretroviral regimen for at least the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Does documentation show a history of treatment failure?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
6. Is there known or suspected virologic resistance to cabotegravir or rilpivirine?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
7. Does documentation show that the member has the ability and willingness to visit the clinic to receive injection?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
8. Does the member have an active hepatitis B virus (HBV) infection?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
9. Has the member tried and failed all appropriate preferred HIV regimens?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
10. Does documentation show the member has one of the following: <ul style="list-style-type: none"> • Severe gastrointestinal issues that likely limits absorption or tolerance of oral medications 	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

<ul style="list-style-type: none"> • 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?	<input type="checkbox"/>	<input type="checkbox"/>	
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:			

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

Policy PHARM-HU-119
Origination Date: 01/01/2022
Reviewed/Revised Date: 05/17/2023
Next Review Date: 05/17/2024
Current Effective Date: 06/01/2023

Confidentiality Notice

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.