HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM
APRETUDE®

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:		

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: ☐ Apretude ® (cabotegravir)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.			
Questions	**Yes**	**No**	**Comments/Notes**
1. Is the request for an at-risk adult or adolescent (≥ 35 kg) to reduce the risk of sexually acquired HIV-1 infection?	☐	☐	**Please provide documentation**
2. Is the member confirmed to be HIV-negative within 30 days prior to initiation of therapy?	☐	☐	**Please provide documentation**
3. Does the member have an intolerance or contraindication to emtricitabine and tenofovir disoproxil fumarate (generic Truvada®)?	☐	☐	**Please provide documentation**
4. Does the member have documentation of tenofovir disoproxil fumarate induced renal dysfunction?	☐	☐	**Please provide documentation**
5. Did the member have new onset or worsening of renal dysfunction after starting a tenofovir disoproxil fumarate regimen?	☐	☐	**Please provide documentation**
6. Is the member taking any medications that are considered medically necessary and likely to cause or exacerbate renal dysfunction?	☐	☐	**Please provide documentation**
7. Does the member have documentation of renal dysfunction with creatinine clearance <60 mL/min?	☐	☐	**Please provide documentation**
8. Does the member have documentation of osteoporosis confirmed by DEXA Scan OR do serial DEXA scans show osteopenia with progression of bone loss?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	

2. Has Apretude shown to be tolerable and effective?	☐	☐	**Please provide documentation**
3. Does the member have a continued medical need for therapy?	☐	☐	**Please provide documentation**
4. Does the member have a documented negative HIV-1 test every 3 months?	☐	☐	**Please provide documentation**

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-HU-134
Origination Date: 05/09/2022
Reviewed/Revised Date: 05/17/2023
Next Review Date: 05/17/2024
Current Effective Date: 06/01/2023