

PRIOR AUTHORIZATION REQUEST FORM

Cabenuva

For authorization, please answer each question and fax this form PLUS chart notes back to RealRx Medicaid 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 Pharmacy Customer Service for assistance.

- Healthy U: 855-856-5694
- Healthy U CHIP: 855-203-3633
- Health Choice Utah: 855-864-1404

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:

Product Requested: Cabenuva (cabotegravir/rilpivirine extended-release injectable suspension)

Directions for Use: _____

Criteria for Approval (ALL of the following criteria must be met):	Yes	No
1. Is the patient 12 years of age or older and weighs at least 35 kg?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the patient have a diagnosis of human immunodeficiency virus type-1 (HIV-1) ?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the medication being prescribed by or in consultation with an HIV specialist or a provider specializing in the treatment of infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the patient been virologically suppressed (HIV-1 RNA < 50 copies/ml) on a stable antiretroviral therapy (ART) for at least 3 months with submitted laboratory level? Current regimen: _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the provider attest that the patient is NOT receiving Cabenuva concomitantly with any other ART medication?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the provider attest that the patient does NOT have a history of ART treatment failure?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the provider attest that the patient does NOT have a suspected resistance to either cabotegravir or rilpivirine?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does the provider attest to manage planned and unplanned missed doses per the prescribing information?	<input type="checkbox"/>	<input type="checkbox"/>

Reauthorization

1. Has the provider submitted an updated letter with medical justification and updated chart notes demonstrating positive clinical response?	<input type="checkbox"/>	<input type="checkbox"/>
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PRESCRIBER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

Physician's Signature:	Date:
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Initial Authorization: Up to six (6) months

Reauthorization: Up to one (1) year

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Policy: PHARM-HYB-174
Origination Date: 01/01/2026
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 01/01/2026

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