

## Jonas PRIOR AUTHORIZATION REQUEST FORM

### Rukobia

**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:  Rukobia (fostemsavir)

Directions for Use: \_\_\_\_\_

**Criteria for Approval (ALL of the following criteria must be met):**

	Yes	No
1. Is the patient 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the medication being prescribed by or in consultation with an infectious disease specialist?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the patient have a diagnosis of HIV-1 infection?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the patient have resistance, intolerance, or contraindication to at least 2 different combinations of guideline-recommended initial treatments with 2 NRTIs plus (a) INSTI, (b) Boosted PI, or (c) NNRTI?  Drug/Dose: _____ Reason for Failure: _____  Drug/Dose: _____ Reason for Failure: _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the provider attest that Rukobia will be used concomitantly with other antiretroviral(s) indicated for the treatment of HIV-1 infection?  Medication(s): _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the provider attest that the patient is NOT taking CYP3A inducers concomitantly, which may significantly reduce fostemsavir plasma concentration, resulting in a loss of virologic response? These drugs include, but are not limited to the following: <input type="checkbox"/> Androgen receptor inhibitor: enzalutamide <input type="checkbox"/> Anticonvulsants: carbamazepine, phenytoin <input type="checkbox"/> Antimycobacterial: rifampin <input type="checkbox"/> Antineoplastic: mitotane <input type="checkbox"/> Herbal product: St. John's wort (Hypericum perforatum)	<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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2. Is Rukobia being used concomitantly with other antiretroviral(s) indicated for the treatment of HIV-1 infection?  Medication(s): _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>PRESCRIBER CERTIFICATION</b>		
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.		
Physician's Signature:	Date:	

**Initial Authorization:** Up to six (6) months

**Reauthorization:** Up to one (1) year

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

Policy: PHARM-HYB-187  
 Origination Date: 01/01/2026  
 Reviewed/Revised Date:  
 Next Review Date:  
 Current Effective Date: 01/01/2026

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