

PRIOR AUTHORIZATION REQUEST FORM

Yeztugo

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: <input type="checkbox"/> Yeztugo (lenacapavir)			
Directions for Use: _____			
Criteria for Approval (ALL of the following criteria must be met):		Yes	No
1. Does the patient weigh at least 35kg?		<input type="checkbox"/>	<input type="checkbox"/>
2. Is the patient being prescribed Yeztugo for pre-exposure prophylaxis (PrEP) to reduce the risk of 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 had a confirmed negative HIV-1 test within two weeks prior to treatment initiation?		<input type="checkbox"/>	<input type="checkbox"/>
5. Has the patient tried and failed a preferred oral PrEP regimen AND Apretude (cabotegravir), or has the provider given rationale for the lack thereof?		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Oral PrEP medication: _____ Rationale for lack thereof: _____			
<input type="checkbox"/> Details of trial and failure of Apretude (cabotegravir): _____ Rationale for lack thereof: _____			
6. Does the provider have plans for managing planned and unplanned missed doses per the prescribing information?		<input type="checkbox"/>	<input type="checkbox"/>
7. Does the provider attest that the patient agrees to the required testing and every 6-month injection dosing schedule, and that the provider has counseled the patient about the importance of adhering to scheduled Yeztugo dosing visits to help reduce the risk of acquiring HIV-1 infection and development of resistance?		<input type="checkbox"/>	<input type="checkbox"/>
8. Does the provider attest to follow supplemental dosing recommendations per the prescribing information if the patient is initiated on strong or moderate CYP3A4 inducers?		<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"/>

2. Has the provider submitted a confirmed negative HIV-1 test taken within the past 2 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
PRESCRIBER CERTIFICATION		
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

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Policy: PHARM-HYB-191
 Origination Date: 01/01/2026
 Reviewed/Revised Date:
 Next Review Date:
 Current Effective Date: 01/01/2026

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