UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Cabenuva (cabotegravir/rilpivirine extended-release injectable suspension)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

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

- ❑ 12 years of age or older and weighs at least 35 kg.
- ❑ Diagnosis of human immunodeficiency virus type-1 (HIV-1).
- ❑ Prescribed by or in consultation with an infectious disease specialist.
- ❑ Patient has 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: _____
- ❑ Patient is **NOT** receiving Cabenuva concomitantly with any other ART medication.
- ❑ Patient has no history of ART treatment failure.
- ❑ Patient does not have suspected resistance to either cabotegravir or rilpivirine.
- ❑ Prescriber will manage planned and unplanned missed doses per the prescribing information

Re-authorization Criteria:
Updated letter with medical justification or updated chart notes demonstrating positive clinical response.

Initial Authorization: Up to six (6) months
Re-authorization: Up to one (1) year

Note: Use appropriate HCPCS code for billing
Coverage and Reimbursement code look up: https://health.utah.gov/stplan/lookup/CoverageLookup.php
HCPCS NDC Crosswalk: https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php

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

_____ _____
Prescriber's Signature Date