Rukobia (fostemsavir)

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:
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 (at least one of the following criteria must be met):

- ❑ 18 years of age or older.
- ❑ Prescribed by or in consultation with an infectious disease specialist.
- ❑ Resistance, intolerance, or contraindication to at least one agent from 3 of the following drug classes:

Medication/Dose	**Details of Failure**	**Chart Note Pg #**
Nucleoside Reverse-Transcriptase Inhibitor (NRTI) Medication:		
Non-Nucleoside Reverse-Transcriptase Inhibitor (NNRTI) Medication:		
Protease inhibitor Medication:		
C-C Chemokine Receptor type 5 (CCR5) antagonist Medication:		
Fusion inhibitor Medication:		

- ❑ Rukobia will be used concomitantly with other antiretroviral(s) indicated for the treatment of HIV-1 infection.
  Medication(s): _____ Chart note page #: _____

- ❑ 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:
  - Androgen receptor inhibitor: enzalutamide
  - Anticonvulsants: carbamazepine, phenytoin
  - Antimycobacterial: rifampin
  - Antineoplastic: mitotane
  - Herbal product: St John's wort (Hypericum perforatum)

Re-authorization Criteria:
Updated letter with medical justification or updated chart notes demonstrating maintenance of virological suppression with HIV-1 RNA less than 50 copies/mL.

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

PROVIDER CERTIFICATION

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

_____ _____

Prescriber's Signature Date