UnitedHealthcare Community Plan

Antivirals : HIV – Cabenuva (cabotegravir/rilpivirine) - Washington

Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**

This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.

Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
   - If yes, does the member have consistent monthly medication use within the last 6 months? ☐ Yes ☐ No

2. What is patient's diagnosis?
   ☐ HIV-1
   ☐ Other. Specify: _____

3. Is the patient ART-experienced? ☐ Yes ☐ No
   - If yes, Has the patient had virologic suppression for at least 6 months (HIV-1 RNA < 50 copies/mL)?
     ☐ Yes ☐ No

4. Does the patient have a history of any of the following (check all that apply):
   ☐ A history of treatment failure to cabotegravir or rilpivirine
   ☐ Resistance to cabotegravir or rilpivirine
   ☐ None of the above

5. Does patient have documentation of any of the following (check all that apply)?
   ☐ Neurodiversity or a behavioral health condition which impairs the patient's ability to manage multiple or daily medications
   ☐ Severe substance use disorder
   ☐ Diagnosed swallowing disorder
   ☐ Cognitive impairment requiring assistance with activities of daily living
   ☐ None

6. Will Cabenuva be used in combination with other ART medications?
   ☐ Yes. Specify: _____
   ☐ No

7. Will the patient be using any of the following medications (check all that apply)?

☐ Carbamazepine	☐ Dexamethasone (more than single dose treatment)	☐ Phenytoin
☐ Oxcarbazepine	☐ Phenobarbital	☐ St. John's Wort
☐ Rifampin	☐ Rifapentine	☐ Rifabutin

8. Indicate what date the patient will be initiated on oral cabotegravir and rilpivirine therapy: _____

CHART NOTES AND LABS ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date