

**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: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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**

**Antivirals : HIV –
Cabenuva (cabotegravir/rilpivirine) - Washington
Prior Authorization Request Form**

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

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

3. Is the patient treatment naïve? Yes No

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

5. Does patient have any of the following (check all that apply)?
 - Neurodiversity or a behavioral health condition which impairs the patient’s ability to manage multiple 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)?

<input type="checkbox"/> Carbamazepine	<input type="checkbox"/> Dexamethasone (more than single dose treatment)	<input type="checkbox"/> Phenytoin
<input type="checkbox"/> Oxcarbazepine	<input type="checkbox"/> Phenobarbital	<input type="checkbox"/> St. John’s Wort
<input type="checkbox"/> Rifampin	<input type="checkbox"/> Rifapentine	<input type="checkbox"/> Rifabutin

TheraCom Pharmacy contact information:

TheraCom VIIV Specific Team numbers Phone: 1-844-276-6299 Fax: 1-833-904-1881	TheraCom Mailing Address to locate pharmacy in e-Prescribing systems Theracom 345 International Blvd Ste 200 Brooks, KY 40109
---	--

CHART NOTES AND LABS ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date
----------------------	----------------------	------

Confidentiality Notice: This transmission contains confidential information belonging to the sender and UnitedHealthcare. This information is intended only for the use of UnitedHealthcare. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action involving the contents of this document is prohibited. If you have received this telecopy in error, please notify the sender immediately.