

AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-305-671-0200.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Cabenuva™ (cabotegravir/rilpivirine) LAP (Pharmacy)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight: _____ Date: _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- Member is 12 years of age or older
- Member must have a confirmed diagnosis of human immunodeficiency virus type -1 (HIV-1)
- Medication is being prescribed by, or in consultation with, an infectious disease specialist or specialist in HIV treatment
- Member has been stabilized **AND** virologically suppressed on current treatment for at least 3 months, defined as HIV RNA copies <50 copies/mL (**must submit chart notes/progress notes displaying regimen from the past 3 months and laboratory documentation of measured level of RNA copies from the past 30 days**)
- Member has **NOT** experienced any treatment failure and not suspected/known to have resistance to either cabotegravir or rilpivirine

(Continued on next page)

Medication being provided by Specialty Pharmacy – Proprium Rx

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****