SENTARA HEALTH PLANS

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 1-800-750-9692**. 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 may be delayed.**

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

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

Member Name: _____

Member Sentara #: _____ **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 Name/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

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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.*

***Approved by Pharmacy and Therapeutics Committee:** ~~5/15/2021;~~ **7/21/2022**
REVISED/UPDATED/REFORMATTED: ~~9/14/2021;~~ ~~10/8/2021;~~ ~~6/6/2022;~~ ~~8/5/2022;~~ ~~10/5/2023~~**, 2/12/2024**