UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Yeztugo (lenacapavir)

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:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per Dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
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.	

***For treatment of HIV-1 infection indication, see Sunlenca (lenacapavir) PA form**

Criteria for Approval: (*All* of the following criteria must be met)

1. Does the patient weigh at least 35kg? ❑ **Yes** ❑ **No**
2. Is the patient being prescribed Yeztugo for pre-exposure prophylaxis (PrEP) to reduce the risk of HIV-1? ❑ **Yes** ❑ **No**
3. Is the medication being prescribed by or in consultation with an HIV specialist or a provider specializing in the treatment of infectious disease? ❑ **Yes** ❑ **No**
4. Has the patient had a confirmed negative HIV-1 test within two weeks prior to treatment initiation? ❑ **Yes** ❑ **No**
5. Has the patient tried and failed a preferred oral PrEP regimen AND Apretude (cabotegravir), or has the provider given rationale for the lack thereof? ❑ **Yes** ❑ **No**
   - ☐ Oral PreP medication: _____
     - ☐ Rationale for lack thereof: _____
   - ☐ Details of trial and failure of Apretude (cabotegravir): _____
     - ☐ Rationale for lack thereof: _____
6. Does the provider have plans for managing planned and unplanned missed doses per the prescribing information? Chart note page#: _____ ❑ **Yes** ❑ **No**

7. Does the provider attest that the patient agrees to the required testing and every 6-month injection dosing schedule, and that the provider has counseled the patient about the importance of adhering to scheduled Yeztugo dosing visits to help reduce the risk of acquiring HIV-1 infection and development of resistance?
   ❑ **Yes** ❑ **No**
8. Does the provider attest to follow supplemental dosing recommendations per the prescribing information if the patient is initiated on strong or moderate CYP3A4 inducers? ❑ **Yes** ❑ **No**

Reauthorization Criteria:

1. Has the provider submitted an updated letter with medical justification or updated chart notes demonstrating the need for PREP treatment? ❑ **Yes** ❑ **No**
2. Has the provider submitted a confirmed negative HIV-1 test taken within the past 2 weeks?
   ❑ **Yes** ❑ **No**

Initial Authorization: Up to six (6) months
Reauthorization: Up to one (1) year

Note:

- Risk of drug resistance with use of lenacapavir for HIV-1 preexposure prophylaxis in undiagnosed HIV-1 infection

PROVIDER CERTIFICATION

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

_____ _____

Prescriber's Signature Date