Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

Cabenuva® (cabotegravir and rilpivirine)
Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED.

Member Information (required)			**Provider Information (required)**		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if request is for initial trial ❑ Check if request is for recertification of therapy	Directions for Use:	

Clinical Information (required)

Authorization:

- ❑ The recipient has a diagnosis of HIV-1 infection
- ❑ The recipient is currently virologically suppressed (HIV-1 RNA less than 50 copies/mL) on a stable, uninterrupted antiretroviral regimen for at least 6 months
- ❑ The recipient has no history of treatment failure or known/suspected resistance to either cabotegravir or rilpivirine
- ❑ Prescribed by or in consultation with a clinician with HIV expertise
- ❑ Cabenuva® will not be used concurrently with other ART medications

Recipient's weight: _____

Attach any additional comments, diagnoses, symptoms, medications tried or failed, or other information the physician feels is important to this review.

Please note: This request may be denied unless all required information is received. For urgent or expedited requests please call 1-800-711-4555. This form may be used for non-urgent requests and faxed to 1-800-527-0531.