



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:
<input type="checkbox"/> Check if request is for initial trial <input type="checkbox"/> Check if request is for recertification of therapy			Directions for Use:		
Clinical Information (required)					
Authorization:					
<input type="checkbox"/> The recipient has a diagnosis of HIV-1 infection					
<input type="checkbox"/> 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					
<input type="checkbox"/> The recipient has no history of treatment failure or known/suspected resistance to either cabotegravir or rilpivirine					
<input type="checkbox"/> Prescribed by or in consultation with a clinician with HIV expertise					
<input type="checkbox"/> 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.

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