PRIOR AUTHORIZATION REQUEST

CCR5 Antagonists medications

PATIENT: Name_____
Address:_____
City, State, Zip_____
D.O.B._____
Member ID: _____

Prescriber: Name_____
Address_____
City, State, Zip_____
Phone _____
Fax_____
NPI _____

Medication Requested:
Selzentry® (maraviroc)

Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A Please answer the following questions

1. ☐ Yes ☐ No Has the member been diagnosed as having a positive test for an HIV-1 infection?
2. ☐ Yes ☐ No Has member tested positive only for CCR5 tropisim?
3. ☐ Yes ☐ No Has the member failed therapy in 3 class antiretroviral regimen?
4. ☐ Yes ☐ No Has the member been prescribed additional antiretrovirals besides Selzentry®?

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

SECTION C Reference:

Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. Available at http://aidsinfo.nih.gov/contentfiles/lvguidelines/AdultandAdolescentGL.pdf. Section accessed [11/2019]

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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If you have any questions, call:
800-753-2851