maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Combination medication in a single-tablet regimens for the management of HIV.

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

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

Medication Requested:

Atripla® (efavirenz/emtricitabine/tenofovir disoproxil fumarate)
Complera® (emtricitabine/rilpivirine/tenofovir disoproxil fumarate)
Genvoya® (elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide)
Odefsey® (emtricitabine/rilpivirine/tenofovir alafenamide)
Stribild® (elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil fumarate)
Triumeq® (abacavir/dolutegravir/lamivudine)
Juluca® (dolutegravir/rilpivirine)
Dovato® (dolutegravir/lamivudine)
Delstrigo® (doravirine/lamivudine/tenofovir disoproxil)
Symtuza® (darunavir/cobicistat/emtricitabine/tenofovir alafenamide)

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 the patient tried and failed Biktarvy®? (Defined as lab tests showing plasma HIV RNA VL >200 copies/mL after 2 months of therapy) or is resistance to Biktarvy®?
3. ☐ Yes ☐ No Has the patient tried and failed a combination of Truvada® and Isentress®? (Defined as lab tests showing plasma HIV RNA VL >200 copies/mL after 2 months of therapy) or have resistance to Truvada® and Isentress®?

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.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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