



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.

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 tropism?
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:

Blank lines for documentation

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**