



PRIOR AUTHORIZATION REQUEST

Nucleotide/side Reverse Transcriptase Inhibitors (NRTIs) Medications

PATIENT: Name _____	Prescriber: Name _____
Address: _____	Address _____
City, State, Zip _____	City, State, Zip _____
D.O.B. _____	Phone _____
Member ID: _____	Fax _____
	NPI _____

Medication Requested: _____

- Combivir® (zidovudine/lamivudine)
- Descovy® (emtricitabine/tenofovir alafenamide)
- Emtriva® (emtricitabine; FTC)
- Epzicom® (abacavir/ lamivudine)
- Trizivir® (abacavir/zidovudone/lamivudine)
- Videx® (didanosine)
- Zerit® (stavudine; d4T)

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

- Yes No Has the member been diagnosed as having a positive test for an HIV-1 infection?
- Yes No Has the patient tried and failed Cimduo®, Epivir®, Retrovir®, Viread®, Ziagen®, Truvada? (Defined as lab tests showing plasma HIV RNA VL >200 copies/mL after 2 months of therapy) Or have resistance to any of the preferred medication?

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

SECTION B Physician Signature

_____ PHYSICIAN SIGNATURE

_____ DATE

SECTION C References:

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