



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 Symfi® or Symfi Lo®? (Defined as lab tests showing plasma HIV RNA VL >200 copies/mL after 2 months of therapy) or have resistance to Symfi® or Symfi Lo®?

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**