



## PRIOR AUTHORIZATION REQUEST

### Protease Inhibitors

#### Patient Information:

|                   |  |
|-------------------|--|
| Name:             |  |
| Member ID:        |  |
| Address:          |  |
| City, State, Zip: |  |
| Date of Birth:    |  |

#### Prescriber Information:

|                   |  |
|-------------------|--|
| Name:             |  |
| NPI:              |  |
| Phone Number:     |  |
| Fax Number:       |  |
| Address:          |  |
| City, State, Zip: |  |

#### Requested Medication

|                             |  |
|-----------------------------|--|
| Rx Name:                    |  |
| Rx Strength:                |  |
| Rx Quantity:                |  |
| Rx Frequency:               |  |
| Rx Route of Administration: |  |
| Diagnosis and ICD Code:     |  |

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 note that supporting clinical documentation is required for ALL PA requests.

|   |   |     |    |
|---|---|-----|----|
| 1 | Has the patient had a positive test for a human immunodeficiency virus (HIV)-1 infection?<br>[If no, no further questions.]   | Yes | No |
| 2 | Has the patient tried Norvir, Reyataz, or Kaletra and failed, (defined as lab tests showing plasma HIV RNA VL greater than 200 copies/mL after 2 months of therapy), is resistant to a preferred medication, OR has contraindication to a preferred medication?<br>[If no, no further questions.] | Yes | No |
| 3 | Is this a request for initial or continuation of treatment?<br><input type="checkbox"/> Initial (If checked, no further questions.)   |     |    |

**If you have any  
questions, call:  
1-888-258-8250**

PRV 09.25.24.03



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☐ Continuation (If checked, go to 4)

|   |  |     |    |
|---|--|-----|----|
| 4 | Has the patient been evaluated to confirm treatment response? ACTION<br>REQUIRED: Submit supporting documentation. | Yes | No |
|---|--|-----|----|

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

### **SECTION B:** Physician Signature

\_\_\_\_\_  
PHYSICIAN SIGNATURE

\_\_\_\_\_  
DATE

**FAX COMPLETED FORM TO: 1-833-896-0656**

**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.

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