



PRIOR AUTHORIZATION REQUEST

Combination HIV Products

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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

- | | | | |
|---|---|-----|----|
| 1 | Is this a request for initial or continuation of treatment?
<input type="checkbox"/> Initial (If checked, go to 2.)

<input type="checkbox"/> Continuation (If checked, go to 5) | | |
| 2 | Has the patient had a positive test for a human immunodeficiency virus (HIV)-1 infection?
[If no, no further questions.] | Yes | No |
| 3 | Has the patient tried and failed Biktarvy OR does the patient have resistance to | Yes | No |

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

Version 07.2025



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Biktarvy (defined as lab tests showing plasma HIV RNA VL GREATER THAN 200 copies/mL after 2 months of therapy) OR does the patient have a contraindication to preferred therapy?

[If no, no further questions.]

- | | | | |
|---|---|-----|----|
| 4 | Has the patient tried and failed a combination of Symfi or Symfi Lo OR does the patient have resistance to Symfi or Symfi Lo (defined as lab tests showing plasma HIV RNA VL GREATER THAN 200 copies/mL after 2 months of therapy) OR does the patient have a contraindication to preferred therapy?
[No further questions.] | Yes | No |
| | | | |
| 5 | Has the patient been evaluated to confirm treatment response? ACTION 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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