maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Rukobia

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 the patient 18 years of age or older? [If no, no further questions.]	Yes	No
2	Is the requested medication prescribed by or in consultation with a physician who specializes in the treatment of HIV infection? [If no, no further questions.]	Yes	No
3	What is the diagnosis or indication? [] HIV type 1 (HIV-1) infection (If checked, go to 4)		

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

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[] Other (If checked, no further questions)

4	Is this request for initial therapy or for a continuation of therapy? [] Initial (If checked, go to 5) [] Continuation (If checked, go to 9)		
5	Is the patient failing a current antiretroviral regimen for HIV? [If no, no further questions.]	Yes	No
6	Has the patient exhausted at least FOUR of the following antiretroviral classes defined as elimination of all antiretrovirals within a given class due to demonstrated or projected resistance to the agent(s) in that class: (a) Nucleoside reverse transcriptase inhibitor (Examples include abacavir, didanosine, emtricitabine, lamivudine, stavudine, tenofovir disoproxil fumarate, tenofovir alafenamide, zidovudine); (b) Non-nucleoside reverse transcriptase inhibitor (Examples include delaviridine, efavirenz, etravirine, nevirapine, nevirapine XR, rilpivirine); (c) Protease inhibitor (Examples include atazanavir, darunavir, fosamprenavir, indinavir, nelfinavir, ritonavir, saquinavir, tipranavir); (d) Fusion inhibitor (Examples include Fuzeon [enfuviritide for injection]); (e) Integrase strand transfer inhibitor (Examples of integrase strand transfer inhibitors include raltegravir, dolutegravir, elvitegravir); (f) CCR5 antagonist (Examples include Selzentry [maraviroc tablets])? [If yes, skip to question 8.]	Yes	No
7	Has the patient exhausted at least FOUR of the following antiretroviral classes defined as elimination of all antiretrovirals within a given class due to significant intolerance: (a) Nucleoside reverse transcriptase inhibitor (Examples include abacavir, didanosine, emtricitabine, lamivudine, stavudine, tenofovir disoproxil fumarate, tenofovir alafenamide, zidovudine); (b) Non-nucleoside reverse transcriptase inhibitor (Examples include delaviridine, efavirenz, etravirine, nevirapine, nevirapine XR, rilpivirine); (c) Protease inhibitor (Examples include atazanavir, darunavir, fosamprenavir, indinavir, nelfinavir, ritonavir, saquinavir, tipranavir); (d) Fusion inhibitor (Examples include Fuzeon [enfuviritide for injection]); (e) Integrase strand transfer inhibitor (Examples of integrase strand transfer inhibitors include raltegravir, dolutegravir, elvitegravir); (f) CCR5 antagonist (Examples include Selzentry [maraviroc tablets])? [If no, no further questions.]	Yes	No
8	Will the requested medication be taken in combination with an optimized antiviral background regimen including one or more other antiretroviral agents? [No further questions.]	Yes	No
9	Will the requested medication continue to be taken in combination with an optimized antiviral background regimen including one or more other antiretroviral agents?	Yes	No

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	[If no, no further questions.]		
10	Has the patient responded to a Rukobia-containing regimen, as determined by the prescriber? [Note: Examples of a response are HIV RNA less than 40 cells/mm3, HIV-1 RNA greater than or equal to 0.5 log10 reduction from baseline in viral load.]	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.

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