PRIOR AUTHORIZATION REQUEST

EGRIFTA

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 request for initial therapy or for a continuation of therapy? [] Initial (If checked, go to 7) [] Continuation (If checked, go to 2)		
2	Is the patient currently receiving the requested medication? [If no, skip to question 7.]	Yes	No

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

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3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
8	What is the diagnosis or indication? [] Lipodystrophy associated with human immunodeficiency virus (HIV) injection (If checked, go to 9) [] Other (No further questions)		
9	Has documentation been provided to confirm the patient has human immunodeficiency virus (HIV)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	Has documentation been provided to confirm the patient's waist circumference is 95 cm or greater for males and 94 cm or greater for females? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
11	Has documentation been provided to confirm the patient's waist-to-hip ratio is 0.94 or greater for males and 0.88 or greater for females? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	Does the provider attest that the patient is on a stable anti-retroviral regimen for at least 8 weeks prior to treatment request (CD4 cell count greater than 100 cells/mm3 and viral load less than 10,000 copies/mL)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
13	Is the patient going to be treated concomitantly with growth hormone medications or insulin-like growth factors? [If yes, no further questions.]	Yes	No
14	Does the provider attest that the patient has been evaluated and is negative for an active malignancy? [If no, no further questions.]	Yes	No

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Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

15	Does the provider attest the patient does not have Type 1 or Type 2 diabetes mellitus (DM)? [If no, no further questions.]	Yes	No
16	Does the provider attest that the patient has been evaluated for disruption of hypothalamic-pituitary axis due to pituitary tumor/surgery, hypophysectomy, or radiation therapy of the head or head trauma? [If no, no further questions.]	Yes	No
17	Does the provider attest that the requested medication is not being used for the treatment of obesity or weight loss? [If no, no further questions.]	Yes	No
18	Is the requested medication being prescribed by, or in consultation with an infectious disease specialist or endocrinologist? [If no, no further questions.]	Yes	No
19	Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved labeled dosing for the indication rheumatoid arthritis? [Note: Dosing: 1.4 mg subcutaneously daily.]	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.

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