

### HIV/AIDS AGENTS PRIOR AUTHORIZATION FORM

Please complete all applicable sections of this prior authorization request form and return to the fax number above. Please include all requested documentation (chart notes, laboratory data, etc.). To review the prior authorization guidelines for HIV/AIDS Agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – HIV/AIDS Agents and Quantity Limits/Daily Dose Limits (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION			PRESCRIBER INFORMATION		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request: _____	Prescriber name: _____		
<input type="checkbox"/> Renewal request	PA#: _____				
Name of office contact: _____			Specialty: _____		
Contact's phone number: _____			State license #: _____		
LTC facility contact/phone: _____			NPI: _____	MA Provider ID#: _____	
RECIPIENT INFORMATION			Street address: _____		
Recipient Name: _____			Suite #: _____	City/state/zip: _____	
Recipient ID#: _____	DOB: _____	Phone: _____	Fax: _____		

### **CLINICAL INFORMATION**

<u>Non-preferred medication requested</u>					
<input type="checkbox"/> abacavir/lamivudine/zidovudine	<input type="checkbox"/> Isentress powder	<input type="checkbox"/> Rescriptor	<input type="checkbox"/> Tybost		
<input type="checkbox"/> Aptivus	<input type="checkbox"/> lamivudine	<input type="checkbox"/> Retrovir	<input type="checkbox"/> Videx EC		
<input type="checkbox"/> Combivir	<input type="checkbox"/> Lexiva	<input type="checkbox"/> Selzentry	<input type="checkbox"/> Viracept		
<input type="checkbox"/> Complera	<input type="checkbox"/> nevirapine ER tab	<input type="checkbox"/> stavudine solution	<input type="checkbox"/> Viramune		
<input type="checkbox"/> Crixivan	<input type="checkbox"/> nevirapine suspension	<input type="checkbox"/> Stribild	<input type="checkbox"/> Viramune XR		
<input type="checkbox"/> Fuzeon* ( <i>specialty drug</i> )	<input type="checkbox"/> Odefsey	<input type="checkbox"/> Triumeq	<input type="checkbox"/> Vitekta		
<input type="checkbox"/> Intelence	<input type="checkbox"/> Prezcoibix	<input type="checkbox"/> Trizivir	<input type="checkbox"/> Zerit		
<input type="checkbox"/> Invirase			<input type="checkbox"/> _____		
Strength: _____	Dosage form: <input type="checkbox"/> capsule/tablet <input type="checkbox"/> suspension/solution <input type="checkbox"/> injection <input type="checkbox"/> powder <input type="checkbox"/> other: _____				
Directions: _____			Quantity: _____	Refills: _____	
Diagnosis: _____			DX code (required): _____		
* Fuzeon injection is part of the Specialty Pharmacy Drug Program. Which specialty pharmacy will be used?			<input type="checkbox"/> Diplomat Specialty Pharmacy <input type="checkbox"/> Walgreen's Specialty Pharmacy		
1. Has the Recipient been taking the requested non-preferred HIV/AIDS Agent within the past 90 days?			<input type="checkbox"/> Yes – <i>submit all supporting documentation of drug regimen and treatment outcome</i> <input type="checkbox"/> No		
2. Has the Recipient tried and failed, or have a contraindication, intolerance, or resistance to, any of the preferred HIV/AIDS Agents? <i>Check all that apply.</i>			<input type="checkbox"/> Yes – <i>submit all supporting documentation of drug regimen and treatment outcome AND/OR results of resistance testing</i>  <input type="checkbox"/> No		
<b><u>NRTIs</u></b> <input type="checkbox"/> abacavir tablet <input type="checkbox"/> stavudine capsule <input type="checkbox"/> Descovy <input type="checkbox"/> Truvada <input type="checkbox"/> didanosine DR <input type="checkbox"/> Videx solution <input type="checkbox"/> Emtriva cap/sol'n <input type="checkbox"/> Viread tab/powder <input type="checkbox"/> EpiVir tab/sol'n <input type="checkbox"/> Ziagen tab/sol'n <input type="checkbox"/> Epzicom <input type="checkbox"/> zidovudine cap/tab/sol'n <input type="checkbox"/> lamivudine/zidovudine tab					
<b><u>NNRTIs</u></b> <input type="checkbox"/> Edurant <input type="checkbox"/> nevirapine tablet <input type="checkbox"/> Sustiva <input type="checkbox"/> Viramune susp.					
<b><u>Combination Products</u></b> <input type="checkbox"/> Atripla <input type="checkbox"/> Evotaz <input type="checkbox"/> Genvoya					
<b><u>Protease Inhibitors</u></b> <input type="checkbox"/> Kaletra <input type="checkbox"/> Prezista <input type="checkbox"/> Norvir cap/tab/sol'n <input type="checkbox"/> Reyataz					
<b><u>Integrase Inhibitors</u></b> <input type="checkbox"/> Isentress tab/chewable <input type="checkbox"/> Tivicay					

**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

Prescriber Signature: _____	Date: _____
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