pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

HIV/AIDS AGENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **HIV/AIDS Agents** and **Quantity Limits/Daily Dose Limits** are available at http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION			PRESCRIBER INFORMATION	
☐New request ☐Renewal request		# of pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			State license #:	
LTC facility contact/phone:			NPI:	MA Provider ID#:
BENEFICIARY INFORMATION			Street address:	
Beneficiary name:			Suite #:	City/state/zip:
Beneficiary ID#:		DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested

☐abacavir/lamivudine tablet	☐Intelence tablet	☐Prezcobix tablet	☐Videx EC capsule
☐abacavir/lamivudine/zidovudine tab	☐Invirase capsule/tablet	☐Rescriptor tablet	☐Viracept tablet
☐Aptivus capsule/solution	☐Isentress powder	☐Retrovir capsule/injection/syrup	☐Viramune suspens
☐atazanavir capsule	☐Isentress HD tablet	☐ritonavir tablet	☐Viramune XR table
☐Combivir tablet	☐Juluca tablet	☐Selzentry solution/tablet	☐Zerit capsule/soluti
☐Crixivan capsule	☐lamivudine solution	☐tenofovir DF tablet	☐Ziagen tablet
☐efavirenz capsule/tablet	☐Lexiva suspension/tablet	☐Triumeq tablet	☐_____
☐Epivir tablet	☐lopinavir/ritonavir solution	☐Trizivir tablet	
☐fosamprenavir tablet	☐nevirapine ER tablet	☐Tybost tablet	

☐**Fuzeon vial*** ***(specialty drug)***

Strength:	Dosage form: ☐capsule ☐tablet ☐suspension/solution ☐injection ☐powder ☐other: _____
Directions:	Quantity: / Refills:
Diagnosis:	Dx code (required):
***Fuzeon injection** is part of the Specialty Pharmacy Drug Program. Which specialty pharmacy will be used?	☐Diplomat Specialty Pharmacy ☐Walgreen's Specialty Pharmacy

1. Has the Beneficiary been taking the requested non-preferred HIV/AIDS Agent within the past 90 days?
   ☐Yes – *Submit all supporting documentation of drug regimen and treatment outcome.*
   ☐No

2. Check all preferred agents in the lists below that the Beneficiary tried and failed, or has a contraindication, intolerance, or resistance to, *and submit all supporting documentation.*

NRTIs		NNRTIs	Complete Regimen Product
☐abacavir solution/tablet	☐lamivudine/zidovudine tab	☐Edurant tablet	☐Atripla tablet
☐Cimduo tablet	☐stavudine capsule	☐nevirapine tablet	☐Biktarvy tablet
☐Descovy tablet	☐Truvada tablet	☐Sustiva capsule/tablet	☐Complera tablet
☐didanosine DR capsule	☐Videx solution		☐Genvoya tablet
☐Emtriva capsule/solution	☐Viread tablet/powder	**Protease Inhibitors**	☐Odefsey tablet
☐Epivir solution	☐Ziagen solution	☐Evotaz tablet	☐Stribild tablet

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☐ Epzicom tablet
☐ lamivudine tablet
☐ zidovudine cap/tab/syrup
☐ Kaletra solution/tablet
☐ Norvir solution/tablet
☐ Prezista suspension/tablet
☐ Reyataz capsule/powder
☐ Symfi tablet
☐ Symfi Lo tablet

Integrase Inhibitors
☐ Isentress chewable/tablet
☐ Tivicay tablet

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

Prescriber Signature:	**Date**: