Antivirals – HIV Combinations

Please fax this completed form to (866) 399-0929 OR mail to: Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
   If yes, has patient's condition worsened?
   ☐ Yes. Specify reason: ☐ Viral load < 200 copies/mL ☐ Increasing CD4 cell count
   ☐ No

2. What is patient's diagnosis?
   ☐ HIV-1
   ☐ Other. Specify:

3. Is patient treatment naïve? ☐ Yes ☐ No

4. Does patient have Hepatitis B virus (HBV)? ☐ Yes ☐ No
   If yes:
   Is hepatic function being closely monitored? ☐ Yes ☐ No
   Has patient initiated an anti-HBV treatment? ☐ Yes ☐ No

5. What is the patient's current weight? kg Date taken:

6. Does patient have hepatic impairment? ☐ Yes ☐ No
   If yes: ☐ Moderate (Child-Pugh Class B) ☐ Severe (Child-Pugh Class C)
   ☐ Other. Specify:

7. What is the patient's creatinine clearance? mL/min Date taken:

8. Will patient be using any of the following medications? (check all that apply)

☐ Alfusozin	☐ Carbamazepine	☐ Colchicine	☐ Cisapride
☐ Dexamethasone	☐ Dofetilide	☐ Dronedarone	☐ Elbasivir/Grazoprevir
☐ Elbasvir	☐ Enzalutamide	☐ Ergot Derivatives	☐ Grazoprevir
☐ Ivabradine	☐ Lurasidone	☐ Lomitapide	☐ Midazolam
☐ Mitotane	☐ Naloxegol	☐ Oxcarbazepine	☐ Phenobarbital
☐ Phenytoin	☐ Pimozide	☐ PPIs	☐ Ranolazine
☐ Rifampin	☐ Rifapentine	☐ Sildenafil	☐ Statins
☐ St John's Wort	☐ Triazolam		

9. If patient is of childbearing potential, does patient have a confirmed negative pregnancy test? ☐ Yes ☐ No

10. Does patient have an inability to maintain an undetectable viral load on preferred separate agents due to non-adherence? ☐ Yes ☐ No

11. Is this prescribed by or in consultation with a specialist in infectious disease or HIV? ☐ Yes ☐ No

Complete only for:
Lamivudine/tenofovir disoproxil (Temixys):

12. Does patient have a documented allergy to inactive ingredients contained in commercially separate agents **AND** Cimduo? ☐ Yes ☐ No

Complete only for:
Darunavir/cobicistat/emtricitabine/tenofovir alafenamide (Symtuza):

13. Has patient been stable on an ART regimen for at least the past 6 months with no history of treatment of treatment failure on current regimen? ☐ Yes ☐ No

Complete only for:
Darunavir/cobicistat/emtricitabine/tenofovir alafenamide (Symtuza)
Bictegravir/emtricitabine/tenofovir alafenamide (Biktarvy)

14. Check all that apply for patient:
    - ☐ Requires renal hemodialysis
    - ☐ Hypertension
    - ☐ Diabetes
    - ☐ Hepatitis C
    - ☐ African American with family history of kidney disease
    - ☐ High risk for bone complications as determined by a history of:
        - ☐ Arm or hip fracture with minimal trauma
        - ☐ Vertebral compression factor
        - ☐ Chronic kidney with proteinuria, low phosphate or is grade 3 or worse
        - ☐ T-score ≤ -2.0 (DXA) at the femoral neck or spine
        - ☐ Chronic, high-dose glucocorticoid-therapy (5 mg/day of prednisone or equivalent for at more than two (2) months
            - What is the diagnosis requiring glucocorticoid regimen?
            - What is patient's current glucocorticoid regimen?
            - What is the expected duration of therapy of glucocorticoid regimen?

CHART NOTES ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date

Envolve Pharmacy Solutions will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)