



Antivirals – HIV Combinations

Please fax this completed form to (833) 645-2734 OR mail to: Pharmacy Services | 5 River Park Place East, Suite 210 | Fresno, CA 93720. You can also complete online at CoverMyMeds.com.

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 shown continued medication adherence with no breaks in therapy? Yes 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)

<input type="checkbox"/> Alfuzozin	<input type="checkbox"/> Carbamazepine	<input type="checkbox"/> Colchicine	<input type="checkbox"/> Cisapride
<input type="checkbox"/> Dexamethasone	<input type="checkbox"/> Dofetilide	<input type="checkbox"/> Dronedaron	<input type="checkbox"/> Elbasvir/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

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 \leq -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

Pharmacy Services 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.)