

Antivirals : HIV Combinations - Washington Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.

**This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.**

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		
Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____		

Section B - Provider Information

First Name:	Last Name:	M.D./D.O.
Address:	City:	State: ZIP code:
Phone:	Fax:	NPI #: Specialty:
Office Contact Name / Fax attention to:		

Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

1. Has patient used this medication within the last 6 months? Yes No
 If yes, contact patient's pharmacy. The pharmacy may submit the claim with Expedited Authorization (EA) 85000000007: Continuation of antiviral treatment.

2. What is the intended use?
 HIV-1 Treatment
 Other. Specify: _____

3. Is patient treatment naïve? Yes No
 If no:
 - Is patient virologically suppressed with HIV-1 RNA < 50 copies/mL? Yes No
 - Has patient been adherent on an ART regimen for at least the past 6 months? Yes No
 - Does patient have a history of treatment failure? Yes No
 - Does patient have known substitutions associated with resistance to the individual components the requested product? Yes No

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

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

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

7. 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"/> Dexamethasone
<input type="checkbox"/> Dofetilide	<input type="checkbox"/> Enzalutamide	<input type="checkbox"/> Elbasivir/Grazoprevir	<input type="checkbox"/> Lurasidone
<input type="checkbox"/> Mitotane	<input type="checkbox"/> Other ART products	<input type="checkbox"/> Oxcarbazepine	<input type="checkbox"/> Phenobarbital
<input type="checkbox"/> Phenytoin	<input type="checkbox"/> Pimozide	<input type="checkbox"/> Rifampin	<input type="checkbox"/> Rifapentine
<input type="checkbox"/> St John's Wort			
<input type="checkbox"/> Proton pump inhibitors (i.e. esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole)			

8. Does patient documentation in medical records of any of the following? (check all that apply)
 - Significant drug interaction
 - Allergy to inactive ingredients contained in commercially separate agents
 - Neurodiversity or a behavioral health condition which impairs the patient's ability to manage multiple medications
 - Severe substance use disorder
 - Diagnosed swallowing disorder
 - Cognitive impairment requiring assistance with activities of daily living

9. **Please list any additional factors or circumstances not highlighted above that would support the medical necessity of this request.**

Member First name:	Member Last name:	Member DOB:
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Complete only for:

Darunavir/cobicistat/emtricitabine/tenofovir alafenamide (Symtuza)

Bictegravir/emtricitabine/tenofovir alafenamide (Biktarvy)

10. Check all that apply for patient:

- Requires renal hemodialysis
- Hypertension
- Diabetes
- Hepatitis C
- African American with family history of kidney disease
- CrCl has decreased \geq 25% from baseline
- High risk for bone complications as determined by a history of:
 - Arm or hip fracture with minimal trauma
 - Vertebral compression fracture
 - T-score \leq -2.0 (DXA) at the femoral neck or spine
 - Taking glucocorticosteroids for more than two (2) months
 - What is the diagnosis requiring a chronic glucocorticoid regimen? _____
 - What is patient's current glucocorticoid regimen? _____
 - What is the expected duration of therapy of glucocorticoid regimen? _____

CHART NOTES and LAB TESTS ARE REQUIRED FOR THIS REQUEST

Prescriber signature	Prescriber specialty	Date
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