UnitedHealthcare Community Plan

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: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ 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? □ Yes □ 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

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Member First name:	Member Last name:	Member DOB:

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)

   ☐ Alfusozin ☐ Carbamazepine ☐ Colchicine ☐ Dexamethasone
   ☐ Dofetilide ☐ Enzalutamide ☐ Elbasivir/Grazoprevir ☐ Lurasidone
   ☐ Mitotane ☐ Other ART products ☐ Oxcarbazepine ☐ Phenobarbital
   ☐ Phenytoin ☐ Pimozide ☐ Rifampin ☐ Rifapentine
   ☐ St John's Wort
   ☐ 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.**

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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 ≥ 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 ≤ -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