

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 for a list of preferred alternatives**

|                    |                   |             |
|--------------------|-------------------|-------------|
| Member First name: | Member Last name: | Member DOB: |
|--------------------|-------------------|-------------|

**Clinical and Drug Specific Information**

**ALL REQUESTS**

|  |  |
|--|--|
| <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> | <b>Does the patient have one of the following diagnoses?</b> <i>(If yes, check which applies)</i><br><input type="checkbox"/> HIV<br><input type="checkbox"/> Post exposure prophylaxis  |
| <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> | <b>Is the patient currently on Stribild or Genvoya therapy?</b><br><i>If yes, list medication and start date:</i>  |
| <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> | <b>Is the patient an appropriate candidate for any of the following?</b> <i>(If yes, check which applies)</i><br><input type="checkbox"/> Triumeq (abacavir/dolutegravir/lamivudine)<br><input type="checkbox"/> Isentress/Isentress HD (raltegravir) plus Cimduo (lamivudine/tenofovir disoproxil)<br><input type="checkbox"/> Tivicay (dolutegravir) plus Cimduo (lamivudine/tenofovir disoproxil)<br><input type="checkbox"/> Juluca (dolutegravir/rilpivirine) |

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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