PRIOR AUTHORIZATION REQUEST

Combination HIV Products

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Is this a request for initial or continuation of treatment? [] Initial (If checked, go to 2.) [] Continuation (If checked, go to 5)		
2	Has the patient had a positive test for a human immunodeficiency virus (HIV)-1 infection? [If no, no further questions.]	Yes	No
3	Has the patient tried and failed Biktarvy OR does the patient have resistance to Biktarvy (defined as lab tests showing plasma HIV RNA VL GREATER THAN 200	Yes	No

If you have any questions, call: 1-888-258-8250

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	copies/mL after 2 months of therapy) OR does the patient have a contraindication to preferred therapy? [If no, no further questions.]		
4	Has the patient tried and failed a combination of Symfi or Symfi Lo OR does the patient have resistance to Symfi or Symfi Lo (defined as lab tests showing plasma HIV RNA VL GREATER THAN 200 copies/mL after 2 months of therapy) OR does the patient have a contraindication to preferred therapy? [No further questions.]	Yes	No
5	Has the patient been evaluated to confirm treatment response? ACTION REQUIRED: Submit supporting documentation.	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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