

Member Name: _____ Member ID: _____ Member DOB: _____
Drug Name: _____ Strength: _____ Directions: _____
Physician Name: _____ Physician Phone #: _____ Specialty: _____
Physician Fax #: _____ Pharmacy Name: _____ Pharmacy Phone: _____

Horizon NJ Health
Antiretroviral Medications – Medical Necessity Request
****Please complete pages 1 and 2 for New/Initial requests****

General Information

1. Is the request for Abacavir containing product (such as Ziagen, Epzicom, Trizivir or Triumeq)? **Yes or No**
-If Yes, was member tested for HLA-B*5701 allele? **Yes or No**
-If Yes, what were the results of the test? _____
2. Is the request for Maraviric containing product (Selzentry)? Yes or No
-If Yes, has member had a co-receptor tropism assay showing susceptibility to CCR5 inhibitors? Yes or No
3. What is the member's most recent creatinine clearance (CrCL) level in ml/min? _____ Date Taken: _____
4. Please also provide the following:
 - Serum Creatinine (mg/dl): _____ Date Taken: _____
 - Current weight: _____ lbs or _____ kg
 - Height: _____ (feet/inches)

Diagnosis Information (please indicate diagnosis and answer related questions):

- HIV**
- AIDS**
- Infant Antiretroviral Prophylaxis**
- a. What is the member's current weight? _____ pounds _____ ounces or _____ kilograms. Date Taken: _____
 - b. What is the member's gestational age in weeks? _____
 - c. What is the member's birth weight? _____ pounds _____ ounces or _____ kilograms

Pre-Exposure Prophylaxis (PrEP)

1. Which of the following criteria does the member meet?
 - Sexually-active
 - Partner with known HIV
 - Injection drug user
 - NONE
2. Will this medication be part of a comprehensive prevention strategy? **Yes or No**
3. Has the member recently had an HIV-1 test? **Note: Please fax the lab results for the HIV-1 test from within past 90 days.*
 - Yes**
 - Result: Positive Negative
 - Date taken: _____
 - No**: Please provide the clinical reason why an HIV-1 test has not been performed.

4. Will the member be screened for HIV-1 at least once every 3 months while taking this medication?
 - Yes**
 - No**: Please provide the reason why the member will not be screened for HIV-1.

5. Will the member be tested for normal renal function at least every 6 months? **Yes or No**

Physician office's signature* _____ Print Name _____

***Form must be completed and signed by physician or licensed representative from the physician's office**

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Post-Exposure Prophylaxis (PEP) [example: needle stick, sexual assault]

1. Will HIV-1 tests be performed at baseline, 4-6 weeks, 3 months, and 6 months following exposure?

Yes

No: Please provide the reason why HIV-1 tests will not be performed at the recommended time points.

2. Was care sought within 72 hours after potential exposure? **Yes or No**

Chronic Hepatitis B

1. Which specialist is prescribing the medication(s): Gastroenterology, Infectious Disease, Hepatology, Liver Transplant,

Other: _____

2. Has member previously received Chronic Hepatitis B therapy such as Epivir, Viread, Tyzeka, Baraclude or Hepsera? **Yes or No**

- If Yes, answer below	- If No, answer below
<input type="checkbox"/> Member remains HBsAg-positive despite treatment <input type="checkbox"/> Member has HBeAg-positive Chronic Hepatitis B, has cirrhosis and seroconverted to anti-HBe while on therapy <input type="checkbox"/> Member is has HBeAg-negative immune-active Chronic Hepatitis B	<input type="checkbox"/> Member has immune-active phase Chronic Hepatitis B <input type="checkbox"/> Member has cirrhosis or significant necroinflammation (moderate to severe) <input type="checkbox"/> Member is pregnant with HBV DNA level greater than 200,000 IU/mL <input type="checkbox"/> Member is between age 2 to 17 years is HBeAg-positive with elevated ALT. - Provide current ALT levels _____

Other: _____

Physician office's signature* _____ Print Name _____

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****Complete this page for Subsequent request****

Diagnosis Information (please indicate diagnosis and answer related questions):

Pre-Exposure Prophylaxis (PrEP)

1. Has the member's diagnosis changed since the previous request? **Yes or No**
If Yes, please go to initial request page and fill out information related to new diagnosis
2. Will this medication be part of a comprehensive prevention strategy? **Yes or No**
3. Is member adherent to therapy? **Yes or No**
4. Has the member recently had an HIV-1 test? **Note: Please fax the lab results for the HIV-1 test from within past 90 days.*
 - Yes**
 - Result: Positive Negative
 - Date taken: _____
 - No:** Please provide the clinical reason why an HIV-1 test has not been performed.

Chronic Hepatitis B

1. Does member remain HBsAg-positive despite treatment? **Yes or No**
2. Does member have HBeAg-positive Chronic Hepatitis B, has cirrhosis and seroconverted to anti-HBe while on therapy?
Yes or No
3. Does member have HBeAg-negative immune-active Chronic Hepatitis B? **Yes or No**

Other: _____

Physician office's signature* _____ Print Name _____

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