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 Maravoric 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 estimated creatinine clearance (CrCL) level in ml/min? _____ Date Taken: _____

4. Is the member receiving chronic hemodialysis (process of filtering and removing waste products from blood)? **Yes or No**

5. 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.
   _____

Continued to pg.2

Physician office's signature*_____ Print Name_____

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

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

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

6. Is the member at risk from receptive vaginal sex? **Yes or No**

□ **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**

□ **Hepatitis B**

1. Does the member have chronic disease? **Yes or No**

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

- If Yes, answer below	**- If No, answer below**
□ Member remains HBsAg-positive despite treatment □ Member has HBeAg-positive Chronic Hepatitis B, has cirrhosis and seroconverted to anti-HBe while on therapy □ Member is has HBeAg-negative immune-active Chronic Hepatitis B	□ Member has immune-active phase Chronic Hepatitis B □ Member has cirrhosis or significant necroinflammation (moderate to severe) □ Member is pregnant with HBV DNA level greater than 200,000 IU/mL □ 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_____
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

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