MOLINA HEALTHCARE

Antivirals – HIV Combinations

Please provide the information below, print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request.
Please FAX responses to: (800) 869-7791. Phone: (855) 322-4082, Options 0,1,2,3

Date of request			
Patient	Date of birth	Molina ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength			Qty/Days supply
Directions for use			

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
- ☐ Sever 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

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MHW-3/25/2021
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