



Antivirals: HIV – Combinations

Please provide the information below, please print your answers, 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: (800) 213-5525, Option 1-2-2.

Date of Request		Date of Birth																					
Patient		Molina Member ID#																					
Pharmacy Name	Pharmacy NPI	Pharmacy Phone Number	Pharmacy Fax Number																				
Prescriber Name	Prescriber NPI	Prescriber Phone Number	Prescriber Fax Number																				
Diagnosis		Medication and Strength																					
Directions for Use			Qty/Days Supply																				
<p>1. Is this request for a continuation of existing therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, has patient shown continued medication adherence with no breaks in therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. What is patient's diagnosis? <input type="checkbox"/> HIV-1 <input type="checkbox"/> Other. Specify:</p> <p>3. Is patient treatment naïve? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Does patient have Hepatitis B virus (HBV)? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: Is hepatic function being closely monitored? <input type="checkbox"/> Yes <input type="checkbox"/> No Has patient initiated an anti-HBV treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. What is the patient's current weight? kg Date taken:</p> <p>6. Does patient have hepatic impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: <input type="checkbox"/> Moderate (Child-Pugh Class B) <input type="checkbox"/> Severe (Child-Pugh Class C) <input type="checkbox"/> Other. Specify:</p> <p>7. What is the patient's creatinine clearance? mL/min Date taken:</p> <p>8. Will patient be using any of the following medications? (check all that apply)</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Alfuzozin</td> <td><input type="checkbox"/> Carbamazepine</td> <td><input type="checkbox"/> Colchicine</td> <td><input type="checkbox"/> Cisapride</td> </tr> <tr> <td><input type="checkbox"/> Dexamethasone</td> <td><input type="checkbox"/> Dofetilide</td> <td><input type="checkbox"/> Dronedaron</td> <td><input type="checkbox"/> Elbasivir/Grazoprevir</td> </tr> <tr> <td><input type="checkbox"/> Elbasvir</td> <td><input type="checkbox"/> Enzalutamide</td> <td><input type="checkbox"/> Ergot Derivatives</td> <td><input type="checkbox"/> Grazoprevir</td> </tr> <tr> <td><input type="checkbox"/> Ivabradine</td> <td><input type="checkbox"/> Lurasidone</td> <td><input type="checkbox"/> Lomitapide</td> <td><input type="checkbox"/> Midazolam</td> </tr> <tr> <td><input type="checkbox"/> Mitotane</td> <td><input type="checkbox"/> Naloxegol</td> <td><input type="checkbox"/> Oxcarbazepine</td> <td><input type="checkbox"/> Phenobarbital</td> </tr> </table>				<input type="checkbox"/> Alfuzozin	<input type="checkbox"/> Carbamazepine	<input type="checkbox"/> Colchicine	<input type="checkbox"/> Cisapride	<input type="checkbox"/> Dexamethasone	<input type="checkbox"/> Dofetilide	<input type="checkbox"/> Dronedaron	<input type="checkbox"/> Elbasivir/Grazoprevir	<input type="checkbox"/> Elbasvir	<input type="checkbox"/> Enzalutamide	<input type="checkbox"/> Ergot Derivatives	<input type="checkbox"/> Grazoprevir	<input type="checkbox"/> Ivabradine	<input type="checkbox"/> Lurasidone	<input type="checkbox"/> Lomitapide	<input type="checkbox"/> Midazolam	<input type="checkbox"/> Mitotane	<input type="checkbox"/> Naloxegol	<input type="checkbox"/> Oxcarbazepine	<input type="checkbox"/> Phenobarbital
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|---|--------------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Phenytoin | <input type="checkbox"/> Pimozide | <input type="checkbox"/> PPIs | <input type="checkbox"/> Ranolazine |
| <input type="checkbox"/> Rifampin | <input type="checkbox"/> Rifapentine | <input type="checkbox"/> Sildenafil | <input type="checkbox"/> Statins |
| <input type="checkbox"/> St John's Wort | <input type="checkbox"/> Triazolam | | |

9. If patient is of childbearing potential, does patient have a confirmed negative pregnancy test? Yes No
10. Does patient have an inability to maintain an undetectable viral load on preferred separate agents due to non-adherence? Yes No
11. Is this prescribed by or in consultation with a specialist in infectious disease or HIV? Yes No

Complete only for:

Lamivudine/tenofovir disoproxil (Temixys):

12. Does patient have a documented allergy to inactive ingredients contained in commercially separate agents AND Cimduo? Yes No

Complete only for:

Darunavir/cobicistat/emtricitabine/tenofovir alafenamide (Symtuza):

13. Has patient been stable on an ART regimen for at least the past 6 months with no history of treatment of treatment failure on current regimen? Yes No

Complete only for:

Darunavir/cobicistat/emtricitabine/tenofovir alafenamide (Symtuza)

Bictegravir/emtricitabine/tenofovir alafenamide (Biktarvy)

14. Check all that apply for patient:

- Requires renal hemodialysis
- Hypertension
- Diabetes
- Hepatitis C
- African American with family history of kidney disease
- High risk for bone complications as determined by a history of:
 - Arm or hip fracture with minimal trauma
 - Vertebral compression factor
 - Chronic kidney with proteinuria, low phosphate or is grade 3 or worse
 - T-score \leq -2.0 (DXA) at the femoral neck or spine
 - Chronic, high-dose glucocorticoid-therapy (5 mg/day of prednisone or equivalent for at more than two (2) months)
 - What is the diagnosis requiring glucocorticoid regimen?
 - What is patient's current glucocorticoid regimen?
 - What is the expected duration of therapy of glucocorticoid regimen?

CHART NOTES ARE REQUIRED WITH THIS REQUEST

Prescriber Signature

Prescriber Specialty

Date