PRIOR AUTHORIZATION REQUEST: Trogarzo Treatment

Please fax form and required documents to Amida Care: 1-646-786-0997

MEMBER INFORMATION	
Name:	Amida Care ID #:
Phone #:	Address:

PRESCRIBER INFORMATION	
Name/Title:	NPI:
Office Phone #:	Office Fax #:
Address:	
Contact Person:	

MEDICATION REQUEST			
Medication: Trogarzo IV Infusion	*Treatment Type*	*Dose*	*Frequency*
	Initial	2000 mg	Day 1
	Maintenance	800 mg	Every 2 weeks
Is this the initial or maintenance treatment?	□ Initial □ Maintenance		
Will the provider listed above be ordering **and** administering this medication?	□ Yes □ No		
If no, specify administering provider and title:			
Where will the patient be administered this medication?			

CLINICAL CRITERIA			
****Please provide labs/documentation required for verification of questions****			
Labs Required:		□ Multidrug resistant HIV Infection □ History of VL >1000 copies/mL for ≥6 months □ ALL ARV sensitivity/resistance tests	
Baseline Labs (MOST RECENT ≤3 mo.)	**Viral Load**	____________________ copies/mL	___/___/______
	CD4 T-Cell Count	______________________ cells/µL	___/___/______
Does the provider agree to submit HIV RNA VL lab tests at 4 weeks and every 6 months after?		□ Yes □ No If NO, please explain: _____________________________	

Prior Treatment History	
Please check all failed ARV classes that apply:	Treatment Outcome (Adverse event / unsuppressed VL / non-adherence / etc.)
□ NRTIs	
□ NNRTIs	
□ PIs/booster	
□ Integrase inhibitors (INSTI)	
□ Other:	
□ Complete list of medication history and/or failed regimens attached	

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PATIENT TREATMENT & EDUCATION READINESS
Treatment Readiness □ Patient demonstration of readiness, willingness, and ability to adhere to the regimen □ Patient understands bi-weekly infusion is add-on therapy to oral medications
Education Readiness □ Patient understands importance of adherence □ Patient understands not to engage in risky and unhealthy behaviors
ADDITIONAL PATIENT NEEDS
AMIDA CARE RESOURCES ARE AVAILABLE TO SUPPORT MEMBER ADHERENCE AND LIFESTYLE MODIFICATION Please check below to request any additional type of support or services for the member: □ Transportation to and from infusions requested □ Personal escort from Amida Care to and from infusions □ Treatment Adherence Program □ Other additional support needed for member by Amida Care for the following type of support/education: ____
Please call 646-757-7979, M-F, 9:00AM – 4:30PM with questions or additional information. You may also provide us with your contact information and the best time to reach you in the space at the top of this document. ________________________________ ____/____/______ Prescriber or Authorized Signature Date