Print Reset

NYRx the Medicaid Pharmacy Program

Antiretrovirals (ARV) Prior Authorization Worksheet

Fax this form to 1-800-268-2990

Processing may be delayed if information submitted is illegible or incomplete.

ENROLLEE INFORMATION

Enrollee Last Name: _____

Enrollee First Name: _____

Enrollee Medicaid ID (2 letters, 5 numbers, 1 letter): _____

Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

National Provider Identifier (NPI) Number: _____

Board Certified Specialty: _____

Prescriber Street Address: _____

City: _____ State: _____ Zip Code: _____

Prescriber Phone: _____ Prescriber Fax: _____

REQUESTED DRUG INFORMATION

Drug Name: _____

Drug Strength: _____

Quantity: _____ Number of Refills: _____

Directions: _____

Is this a New Prescription?

☐ Yes ☐ No

If **No**, date therapy was initiated: _____

Enrollee's Name (Last, First): _____

CLINICAL CRITERIA

1. What diagnosis is this medication being prescribed for?

   ☐ HIV-1 Infection ☐ Chronic Hepatitis B

   ☐ HIV perinatal transmission prophylaxis ☐ HIV pre-exposure prophylaxis (PrEP)

   Other Diagnosis: _____

   Provide the clinical rationale for requesting antiretroviral (ARV) for a diagnosis that is not FDA-approved (**Note**: documentation of the original diagnosis **must** be included with this fax form).

   _____

2. What are the names of the ARV agents the patient is currently on?

   ARV Agent: _____ ARV Agent: _____

   ARV Agent: _____ ARV Agent: _____

   ARV Agent: _____ ARV Agent: _____

Frequency/Quantity/Duration (F/Q/D)

HIV/AIDs diagnosis are limited to no more than:

- 2 protease inhibitors concurrently
- 1 integrase inhibitor concurrently
- 1 booster
- 1 non-nucleoside reverse transcriptase inhibitor concurrently
- 1 co-packaged complete ARV regimen concurrently

3. What is the clinical reason for using two or more antiretroviral medications with the same ingredient?

   _____

4. What is the clinical reason for using more than 5 ARV medications concurrently?

   _____

Enrollee's Name (Last, First): _____

CRITERIA (CONTINUED)

5. What is the clinical reason for using more than 2 protease inhibitors concurrently?

_____

- Crixivan (indinavir, IDV)
- Evotaz (atazanavir/cobicistat)
- Invirase (saquinavir, SQV)
- Kaletra (lopinavir/ritonavir, LPV/r)
- Lexiva (fosamprenavir, FPV)
- Norvir (ritonavir, RTV)
- Prezcobix (darunavir/cobicistat)
- Prezista (darunavir, DRV)
- Reyataz (atazanavir, ATV)
- Viracept (nelfinavir mesylate, NFV)

6. What is the clinical reason for using more than 1 integrase inhibitor concurrently?

_____

- Isentress (raltegravir, RAL)
- Tivicay (dolutegravir) – one of the ingredients in Dovato, Triumeq, and Juluca
- Elvitegravir, EVG – one of the ingredients in Stribild and Genvoya
- Bictegravir, BIC – one of the ingredients in Biktarvy
- Apretude (cabotegravir) – one of the ingredients in Cabenuva

7. What is the clinical reason for using more than 1 non-nucleoside reverse transcriptase inhibitor concurrently?

_____

- Edurant (rilpivirine, RPV)
- Intelence (etravirine, ETR)
- Pifeltro (doravirine)
- Rescriptor (delavirdine mesylate, DLV)
- Sustiva (efavirenz, EFV)
- Viramune (nevirapine, NVP)
- Viramune XR (nevirapine ER)

8. What is the clinical reason for using more than 1 ARV booster drug concurrently?

_____

- Ritonavir
- Cobicistat
- Tivicay (dolutegravir)

Enrollee's Name (Last, First): _____

CRITERIA (CONTINUED)

9. What is the clinical reason for using more than 1 co-formulated and co-packaged complete ARV regimen concurrently or combined use with other ARVs?

_____

- Biktarvy (bictegravir/tenofovir alafenamide/emtricitabine)
- Cabenuva (cabotegravir/rilpivirine)
- Complera (rilpivirine/tenofovir disoproxil fumarate/emtricitabine)
- Delstrigo (doravirine/tenofovir disoproxil fumarate/emtricitabine)
- Dovato (dolutegravir/lamivudine)
- Genvoya (elvitegravir/cobicistat/tenofovir alafenamide/emtricitabine)
- Juluca (dolutegravir/rilpivirine)
- Odefsey (rilpivirine/tenofovir alafenamide/emtricitabine)
- Stribild (elvitegravir/cobicistat/tenofovir disoproxil fumarate/emtricitabine)
- Symfi, Symfi Lo (efavirenz/tenofovir disoproxil fumarate/lamivudine)
- Symtuza (darunavir/cobicistat/tenofovir alafenamide/emtricitabine)

For Juluca:

10. Has the patient been on a stable ARV regimen for at least 6 months?

☐ Yes ☐ No

If **No**, provide reason for use:

_____

11. Does the patient have resistance (confirmed by resistance testing) to the individual components of Juluca (dolutegravir/rilpivirine)?

☐ Yes ☐ No

If **Yes**, provide reason for use:

_____

For Sunlenca:

12. Does the patient have a history of antiretroviral use?

☐ Yes ☐ No

If **No**, provide reason for use:

_____

Enrollee's Name (Last, First): _____

CLINICAL CRITERIA (CONTINUED)

13. Is the patient on a complete antiretroviral regimen concurrently with Sunlenca (lenacapavir)?
    ☐ Yes ☐ No
14. Are you requesting initiation or maintenance therapy?
    ☐ Initiation ☐ Maintenance

For Pre-Exposure Prophylaxis (PrEP) Agents

15. Are you requesting Apretude (cabotegravir), Descovy (emtricitabine/tenofovir alafenamide), Truvada (emtricitabine/tenofovir disoproxil fumarate)?
    ☐ Yes ☐ No
16. What is the date of the last confirmed negative HIV test? (**Note**: last negative test should be within the past 30 days of this PA request and testing is required every 3 months)

    Date: _____

    What is the CPT or procedure code?

    ☐ 0087389 ☐ 0086689 ☐ 0087535 ☐ 0086701

    ☐ 0086703 ☐ 0087904 ☐ 0087901 ☐ 0087390

    ☐ 0087534 ☐ 0087903 ☐ 0087536 ☐ 0087906 ☐ 0087806

If Requesting Descovy:

17. Is the patient male or a transgender woman? (If **Yes**, skip question #18 and #19)
    ☐ Yes ☐ No
18. Descovy is only indicated for pre-exposure prophylaxis in male and transgender women. Are you willing to prescribe Truvada for PrEP?
    ☐ Yes ☐ No

    If **Yes**, skip question #19

If requesting Truvada or its generic:

19. Is Truvada or its generic being used for HIV post-exposure prophylaxis (PEP)?
    ☐ Yes ☐ No

Submission of this form confirms the information is accurate and true, and that the supporting documentation is available for review upon request of the NYSDOH or CMS. The submitter understands that any person who knowingly makes or causes to be made a false record to statement that is material to a Medicaid claim may be subject to civil penalties and treble damages under both federal and NYS False Claims Acts.

Fax Number: 1-800-268-2990
Billing Questions: 1-800-343-9000

For clinical concerns or Preferred Drug Program questions, please visit http://newyork.fhsc.com or call 1-877-309-9493.