***URGENT**

ANTIRETROVIRAL AGENTS
PRIOR AUTHORIZATION
PHYSICIAN FAX FORM

Florida Blue
In the pursuit of health®

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

PLEASE NOTE: Incomplete forms will be returned for additional information. To ensure you are submitting this form correctly, you can complete and submit it directly to us online at www.covermymeds.com
For formulary information, please visit the Florida Blue website at http://www.floridablue.com

PATIENT INFORMATION **Today's Date:** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	

INSURANCE INFORMATION

ID Number:	Group Number:

PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

1. Is the patient currently treated with the requested medication? ☐ Yes ☐ No
   If yes, when was treatment with the requested medication started? _____
2. What is the patient's diagnosis?
   - ☐ Human immunodeficiency virus (HIV) positive
   - ☐ Treatment of post exposure prophylaxis (PEP)
     - Did the patient experience a known or suspected possible exposure to HIV? ☐ Yes ☐ No
     - Was PEP initiated, or will be initiated within 72 hours of exposure? ☐ Yes ☐ No
   - ☐ Treatment of pre-exposure prophylaxis (PreP)
     - Did the patient test negative* for HIV in the past 30 days? ☐ Yes ☐ No
     - Is the patient at substantial risk for HIV acquisition? ☐ Yes ☐ No
     - If currently using, is the patient adherent to PrEP regimen? ☐ Yes ☐ No
     - What is the patient's creatinine clearance* (CrCl)? _____ mL/minute
     - ***Please note: laboratory documentation of HIV test and CrCl must be provided for PreP indication.**
   - ☐ Hepatitis B
   - ☐ Other, please provide ICD code plus description: _____
3. Please list all reasons for selecting the requested **medication, dosing schedule and quantity** over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried.) _____
4. Please list all other medications the patient is **currently taking for treatment of this diagnosis.** _____
5. Please list all medications the patient has **previously tried and failed for treatment of this diagnosis.**

_____	Date: _____	_____	Date: _____
_____	Date: _____	_____	Date: _____
_____	Date: _____	_____	Date: _____

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
1305 Corporate Center Drive
Eagan, Minnesota 55121

TOLL FREE
Fax: 855.212.8110 **Phone: 888.271.3183**