

Georgia ADAP Application for Prior Approval Medications

DATE OF REQUEST:	
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CLIENT INFORMATION:		
Client Name (Last, First, M):		
District/ Clinic where the client is seen:		
<i>Client/ Caregiver</i>		
1) Patient is willing to take (or caregiver to administer) medications as directed.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2) Patient has prior evidence of adherence to therapy and medical care; and prescriber has reasonable expectation that adherent behavior will continue.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3) Patient's home has sufficient storage at the proper temperature.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

DRUGS REQUESTED & REQUIRED INFORMATION:
<i>Please complete the corresponding section for the specific drugs requested and check the appropriate boxes or supply the response/ supporting documentation.</i>

<input type="checkbox"/> Fuzeon (Enfuviritide)
1) Current antiretroviral regimen:
2) Please attach copies of the most recent viral load, CD4 count and all available resistance testing.
3) Proposed optimized regimen:
4) Does the client have a history of moderate to severe adverse events/ intolerances/ allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No
o If yes, what medications?
o Describe the reaction:
5) Does the client have a history of enrollment in a recent study or Expanded Access Program? <input type="checkbox"/> Yes <input type="checkbox"/> No
o If yes, please provide documentation.
<i>If the client's regimen includes Fuzeon, Georgia ADAP recommends completing a "Fuzeon Nurse Connections" enrollment form to arrange for a home visit from a Fuzeon Nurse Educator to help the client to become confident in their ability to reconstitute and inject Fuzeon. The form is available at www.fuzeon.com or via phone at 877-4FUZEON (877-438-9366)</i>

<input type="checkbox"/> Selzentry (Maraviroc)
1) Current antiretroviral regimen:
2) Please attach copies of the most recent viral load, CD4 count, tropism assay test and all available resistance testing.
3) Proposed optimized regimen:
4) Does the client have a history of moderate to severe adverse events/ intolerances/ allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No

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○ If yes, what medications?
○ Describe the reaction:

<input type="checkbox"/> Videx (Didanosine)
1) Current antiretroviral regimen:
2) Length of time on current regimen:
3) Reason for continuing or adding Videx to the regimen:
4) Please attach copies of most recent viral load, CD4 count and all available resistance testing.

<input type="checkbox"/> Zerit (Stavudine)
1) Current antiretroviral regimen:
2) Length of time on current regimen:
3) Reason for continuing or adding Zerit to the regimen:
4) Please attach copies of most recent viral load, CD4 count and all available resistance testing.

<i>Please select requested regimen from the options listed below (Ribavirin will be weight based):</i>			
<input type="checkbox"/> Harvoni (Ledipasvir-sofosbuvir)			
<input type="checkbox"/> Daklinza (Daclatasvir) plus Sovaldi (Sofosbuvir) <input type="checkbox"/> with Ribavirin or <input type="checkbox"/> without Ribavirin			
<input type="checkbox"/> Sovaldi (Sofosbuvir) plus Ribavirin			
<input type="checkbox"/> VIEKIRA PAK <input type="checkbox"/> with Ribavirin or <input type="checkbox"/> without Ribavirin			
<input type="checkbox"/> Technivie <input type="checkbox"/> with Ribavirin or <input type="checkbox"/> without Ribavirin			
<input type="checkbox"/> Zepatier <input type="checkbox"/> with Ribavirin or <input type="checkbox"/> without Ribavirin			
Requested Course of Therapy: <input type="checkbox"/> 12 weeks, <input type="checkbox"/> 16 weeks, or <input type="checkbox"/> 24 weeks			
1) Client is an active and stable ADAP client. (Requirement)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2) Client Weight:		3) Client Age:	
4) Client Sex: 			
5) Current antiretroviral regimen:			
6) List of current non-HIV medications:			
5) Does the client have a history of moderate to severe adverse events/ intolerances/ allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No			

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○ If yes, what medications?
○ Describe the reaction:
7) Please attach copies of the most recent lab work: HIV viral load, CD4 count, CMP, CBC, PT/INR, pregnancy test (if woman of child bearing age), Hepatitis C antibody, Hepatitis C viral load, NS5A resistance-associated polymorphism test (for Zepatier: genotype 1a), Hepatitis C genotype/subtype, i.e. 1a, 1b, etc.
8) Hepatitis C stage: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> compensated cirrhosis <input type="checkbox"/> decompensated cirrhosis ○ Please check the lab performed within the last 12 months and include a copy: <input type="checkbox"/> Liver biopsy <input type="checkbox"/> FIB-4 Calculation <input type="checkbox"/> Non-Invasive Biomarker Testing
9) Please attach the client's MELD or Child-Pugh score.
10) Does the client have a history of Hepatitis C treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No ○ If yes, what treatment?
11) The requesting provider is asking for the State Medical Advisor to make the treatment recommendation. <input type="checkbox"/> Yes <input type="checkbox"/> No

PROVIDER/PRESCRIBER GUIDELINES:
• Patient must have a repeat HIV viral load and CD4 counts performed 12 and 24 weeks after initiation of the regimen to assess effectiveness.
• If CD4 and/or viral load have not improved, clinical improvement (or clinically stable if condition was worsening before) must be documented for continuation of the new regimen.
• The prescriber must review the state guidelines and/or restrictions concerning the use of these medications to determine that the patient qualifies.
• The prescriber should be an experienced HIV/AIDS provider or should consult with a specialist and must have sufficient office/clinic capability to provide patient education and monitoring.
• Guidelines: http://aidsinfo.nih.gov/guidelines / https://dph.georgia.gov/nurse-protocols
• Hepatitis C Guidelines: http://www.hcvguidelines.org/
• Georgia Department of Public Health Hepatitis C Testing Tool Kit: https://dph.georgia.gov/sites/dph.georgia.gov/files/related_files/site_page/ADES_Hepatitis_C_Testing_Toolkit_for_Primary_Care_Providers_in_Georgia.pdf

PRESCRIBER INFORMATION:			
Prescriber Name (Last, First, M):			
Phone:		Email:	
Prescriber Signature:			

REQUEST DETERMINATION:			
Date Received:		Date of Decision:	
<input type="checkbox"/> Request Approved <input type="checkbox"/> Request Denied			
Medical Advisor (Last, First, M):			
Phone:		Email:	
Prescriber Signature:			

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Comments/ Additional Information or Instructions:

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