HealthPAC
Health Program of Alameda County

TELEPHONE: 510-383-1790 FAX: 510-567-6850
Maraviroc (Selzentry™) Prior Authorization Form
HealthPAC - HIV

APPLICATION INFORMATION
This application is required if you are requesting initial authorization for Maraviroc (Selzentry™) to be covered by HealthPAC HIV .

Please fax completed application to the HealthPAC Pharmacy Department:
FAX: 510-567-6850

Complete section one (1) for all patients. Complete section two (2) or three (3) as applicable.

Prescriber name and signature must be included.
For information on completing this form, please call the Alameda County HealthPAC HIV Program pharmacy department: 510-383-1790

Section 1 Patient Name

Birth Date HealthPAC ID or SS#

Section 2 Maraviroc Prior Authorization for new start patients or patients who Have received maraviroc thru another payer (i.e. Medi-Cal, private payer)
Complete this section if tropism assay results have already been determined.

YES NO

☐ ☐ 1. Tropism assay results confirm CCR5 mono-tropic HIV for this program member. *(The date of the tropism assay result must be within 90 days of the prior authorization request)*

☐ ☐ 2. A copy of the results of the tropism assay have been faxed along with this application. *(The date of the tropism assay result must be within 90 days of the prior authorization request unless patient has been receiving maraviroc thru another payer source)*

Section 3 Maraviroc Prior Authorization for patients rolling over from clinical trial or EAP. ***Complete this section for clinical trials and EAP rollover only***

YES NO

☐ ☐ 1. This patient is continuing treatment from previous clinical trial or EAP and *a copy of the assay result is being faxed with this application*.

DATE:	To the best of my knowledge, I certify that the above is accurate and true.	
Prescriber Name	Prescriber Signature	
Phone #	Fax #	DEA #
Pharmacy Name	NABP/NPI #	
Phone #	Fax #	

V.08.12

Ramsell