Telephone: 888-311-7632 FAX: 800-848-4241

Maraviroc (Selzentry™) Prior Authorization Form
California AIDS Drug Assistance Program (ADAP)

APPLICATION INFORMATION

This application is required if you are requesting initial authorization for Maraviroc (Selzentry™) to be covered by the California AIDS Drug Assistance Program (ADAP).

Please fax completed application to Ramsell Public Health Rx: 1-800-848-4241

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 clinical services department: 1-888-311-7632, ext 2635 or 2653

Section 1 Patient Name

Birth Date ADAP or SS#

Section 2 **Maraviroc Prior Authorization for new start patients or patients receiving maraviroc thru another payer (i.e. Medi-Cal, private payer)**
Complete this section if tropism assay results have already been determined and the ADAP client does not need coverage of the tropism assay.

YES NO

☐ ☐ 1. Tropism assay results confirm CCR5 mono-tropic HIV for this ADAP client. *(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 <u>*a copy of the assay result is being faxed with this application*</u>.

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 #	