STATE OF NEVADA

Medication Assistance Program (MAP)
Supplemental Form for Egrifta

TELEPHONE: 888-311-7632 FAX: 800-848-4241 Ramsell

Assistance with prescriptions for Egrifta are only available with a supplemental form through the Nevada Medication Assistance Program. Egrifta™ requires approval from Ramsell before this prescription can be paid by the Nevada Medication Assistance Program.

To be eligible, the following criteria must be met:

- The patient is currently enrolled in the Nevada Medication Assistance program (NMAP) and for NMAP assistance.
- The patient has been denied medication coverage by their insurance plan (if applicable). The Program will bill the client's insurance first and Program will coordinate benefits.
- Egrifta is contraindicated in patients with:
  - disruption of the hypothalamic-pituitary axis,
  - active malignancy,
  - known hypersensitivity to tesamorelin or excipients in EGRIFTA SV, and
  - Pregnancy.

  *Prescriber has confirmed the status of NMAP client and confirms that the patient has no contraindications to drug therapy.

  Provider Signature: _____

First Name	Middle Initial	Last Name
Member ID	**Date of Birth**	**NMAP Cardholder ID #:**

Date of Request: _____

☐ New Therapy
☐ Renewal/Continuation of Therapy If Renewal, Date therapy was initiated_____

*Provide Diagnosis Code and Description_____

Please provide drug information below:

Drug Name & Strength	PACKAGING / NDC	QTY/ DAY SUPPLY	Dosing Frequency/ Length of Therapy
	NDC:	Quantity: Day Supply:	Dosing Frequency: Length of Therapy:

Provider must acknowledge the following with initials:
_____ I have reviewed the prescribing guidelines for possible interactions and issues of the medication regimen.
_____ Patient has been counseled on the high cost of treatment and is willing to be 100% adherent to treatment regimen.
_____ I certify that the information provided is accurate and complete to the best of my knowledge.

Provider Name (Print)	Provider Signature	
Clinic Name:	Phone #	Fax #
Pharmacy Name	Pharmacy Phone #	Fax #
REQUIRED DOCUMENTATION - Please check off and submit ALL required clinical notes/ lab reports in reference to this Failure to provide documentation will delay decision process.		
☐ Denied medication coverage by insurance plan (if applicable)		☐ HIV viral load (within the last 6 months)
☐ CD4 count (within the last 6 months)		

Submit: Please fax completed application to Ramsell at **800-848-4241**.
For additional information, call the Ramsell Help Desk at: 1-888-311-7632.