STATE OF NEVADA

Medication Assistance Program (MAP)
Supplemental Form for TROGARZO (Ibalizumab-uiyk)

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

Assistance with prescriptions for Trogarzo are only available with a supplemental form through the Nevada Medication Assistance Program (NMAP). Trogarzo™ 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 NMAP program and for eligible 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.
- Prescriber has confirmed status of the NMAP client as a heavily treatment-experienced adult with multidrug resistant HIV-1 infection failing current ARV regimen and has provided documentation of resistance in at least two drug classes.
- Trogarzo™ is being used in combination with other antiretrovirals (ARVs).

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_____

Please choose 1 of the 2 options below:

DISPENSING OPTIONS	DRUG NAME & STRENGTH	PACKAGING / NDC	QTY/ DAY SUPPLY	DOSING FREQUENCY/ LENGTH OF THERAPY
☐ **Loading dose**		NDC:	Quantity: Day Supply:	Dosing Frequency: Length of Therapy:
☐ **Maintenance Dose**		NDC:	Quantity: Day Supply:	Dosing Frequency: Length of Therapy:

Most Current CD4 Count and Date (**Provide copy of lab results**)	Most Recent Viral Load and Date (**Provide copy of lab results**)
Name of Medical Facility to receive shipment & conduct Infusion	Name of trained medical professional administering medication

Provider must acknowledge the following with initials:

_____ I have reviewed the prescribing guidelines for possible interactions and issues with the medication regimen.
_____ Patient has been counseled on the high cost of treatment and is willing to be 100% adherent to the 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 request. 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) ☐ Documentation of resistance in at least two drug classes

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