Trogarzo Prior Approval Authorization Form

Instructions:

• Fax completed Trogarzo Prior Approval Authorization Form to the confidential Ryan White Network Fax at 334 - 206-5853 or through encryption email to Tammy.Langlois@adph.state.al.us

• For any questions regarding this form, please contact Tammy Langlois, RN 334-206-9441 or Tammy.Langlois@adph.state.al.us

Note: Prescriber will receive a written response via fax within three business days. If approved, the prescriber will complete the Trogarzo Enrollment Form https://theratechnologies.s3.amazonaws.com/prod/media/TROGARZO_Enrollment_Form.pdf

and submit it to Thera Technologies, which will coordinate the drug distribution. The prescriber should coordinate the payment for any infusion-related costs and supplies with their local Ryan White Part B program, as needed.

Note: Ramsell will not fill any Trogarzo prescriptions without Alabama ADAP Prior Approval Authorization

PATIENT LAST NAME:

PATIENT FIRST NAME:

DATE OF BIRTH:

/ /

TROGARZO CRITERIA FOR USE

• Due to the high cost, a maximum of 10 clients can be approved for Trogarzo assistance through Alabama ADAP at any given time.

• All the criteria below must be met for the patient to be eligible to receive Trogarzo through Alabama ADAP. If the patient does not meet one or more of these criteria, please submit a written explanation for the rationale for requesting Trogarzo for your patient.

Select all that apply:

☐

Adult (≥ 18 years old) with HIV-1 infection

☐

Adherent to current antiretrovirals for ≥ 6 months (Submit clinic note)

☐

Most recent viral load > 200 copies/mL (Submit results)

☐

≤ 2 fully active ARVs from different classes available due to resistance, intolerance, or safety concerns (Submit all current and prior resistance test results and documentation of allergies, intolerances, or safety issues)

☐

≥ 1 fully active agent available to use with Trogarzo - List other antiretrovirals that will be used with Trogarzo:

COVERAGE FOR INSURED CLIENTS

Select one of the options below. Submit documentation of insurance approval or denial for Trogarzo.

☐

Patient's insurance will be the primary payor and ADAP will cover copay only

☐

Patient's insurance has denied coverage and ADAP will be the sole payor

PRESCRIBER NAME (first and last):

DISCIPLINE:

☐ ARNP ☐ DO ☐ MD ☐ PA

PRESCRIBER PHONE:

PRESCRIBER FAX:

PRESCRIBER EMAIL:

OFFICE CONTACT NAME /NUMBER:

☐ I agree to submit HIV viral load results at least every 6 months and CD4 counts when performed while patient is receiving Trogarzo. (Please upload results to Service Point during Eligibility Recertification).

☐ I agree to notify Alabama ADAP immediately upon discontinuation of Trogarzo or if patient is not adherent to therapy. (Use the contact information for Tammy Langlois on the first page of this form.)

☐ I understand that Alabama ADAP may rescind the approval for Trogarzo (with prior provider notice) if the patient is not responding adequately (e.g., rising viral load while on therapy).

PRESCRIBER SIGNATURE:

Date:

/ /

ADAP USE ONLY

CLIENT ID NUMBER:

Date Request Received:

/ /

Request Approved: Yes ☐ No

Reviewed by: