**Rukobia (fostemsavir) Prior Authorization Form**

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| --- |
| **Client name:** Click here to enter text. |
| **Date of birth:** Click here to enter text. | **ADAP ID#:** Click here to enter text. |

**Rukobia is indicated for use only in combination with other antiretrovirals. Please list the entire proposed antiretroviral regimen:**

|  |
| --- |
| Click here to enter text. |

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| --- | --- | --- |
| * **This patient is a new start on Rukobia:**
 |  |  |
| Does this patient have multidrug-resistant HIV-1 infection?  | [ ] Yes | [ ] No |
| Is patient unable to be successfully treated with other ARV’s because of documented intolerable side effects or safety considerations? | [ ] Yes | [ ] No |
| Is client on any medications that are contraindicated with Rukobia (i.e. carbamazepine, phenytoin, rifampin, or St John’s wort)?  | [ ] Yes | [ ] No |
|  |
| * **This patient is continuing Rukobia:**
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| Does patient continue to meet initial criteria listed above? | [ ] Yes | [ ] No |
| Patient has been adherent to Rukobia AND has not experienced toxicity from the drug. | [ ] Yes | [ ] No |
| Does patient have documented clinical improvement compared to baseline?  | [ ] Yes | [ ] No |

Please document mutations here: Click here to enter text.

**\*\*Please attach genotype results and any additional information relevant to this request.**

Provide 3 most recent HIV RNA results:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date:Click to enter a date. | HIV RNA: Click here to enter text. | Date: Click to enter a date. | HIV RNA: Click here to enter text. | Date: Click to enter a date. | HIV RNA:Click here to enter text. |

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| --- |
| Date:Click here to enter text.To the best of my knowledge, I certify that the above information is accurate and true.  |
| Prescriber Signature:  |
| Prescriber Name: Click here to enter text. | NPI: Click here to enter text. |
| Phone #: Click here to enter text. | Fax #:Click here to enter text. |

**Please fax completed form to (302) 320-1373 for review.**