Nevada Office of HIV/AIDS
AIDS Drug Assistance Program (ADAP)
Trogarzo Treatment Request Form

Trogarzo™ (ibalizumab-uiyk) Treatment Request Form

The following is a request form for Nevada ADAP patients to receive Trogarzo™ via IV infusion. Please fill out the following form **COMPLETELY** for your patient to be considered.

Submit the form **AND** the two most recent HIV resistance profiles for the patient to nvadap@health.nv.gov

Do **NOT** write orders for Trogarzo™ until approval from Nevada ADAP has been issued. The prescriber will receive instructions for Trogarzo™ with the approval letter.

The prescriber request will be reviewed by member(s) for the Nevada ADAP formulary committee for medical merit and potential recommendation of alternate or more complete regimen. The form will be reviewed by predetermined ADAP committee member(s) and approval or denial will be communicated to the practitioner within 7 working days. If your subject is denied approval, reasons for denial will be supplied and the practitioner may appeal the decision. The appeal should be in writing and the reviewer may contact you to discuss patient specific issues outlined by the process.

Basic requirements for approval of Trogarzo™ infusion for Nevada ADAP patients:

1. Trogarzo™ request form (filled out in its entirety).
2. Submit the patient's two most recent HIV resistance tests.
3. Patient should be minimally experienced with exposure to four of the six classes of HIV medication.
4. Patient should have extensive HIV resistance and demonstrate the need for Trogarzo™ to build an HIV suppressive regimen.
5. The proposed new optimized HIV regimen that is to contain Trogarzo™ should have an overall susceptibility score (OSS) of two or greater.

For Official Use Only: To be completed by NV ADAP Reviewer(s)

Approved ☐ **Rejected/Returned** ☐

Reviewed by: Date:

Suggestions or comments of reviewers:

Nevada Office of HIV/AIDS
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Date:

Patient Name:
Patient ID Number:
Patient Age:
Patient Sex at Birth: M ☐ F ☐
Requesting Provider Name:
Provider Contact Number:
Provider Fax Number:
Provider Email:

PATIENT'S HIV TREATMENT INFORMATION

Most recent HIV-1 Viral Load:

Date of most recent HIV-1 Viral Load:

Patient's current HIV regimen:

Patient's previous HIV regimen:

Patient's known HIV medication exposure (check medications taken):

☐ Zidovudine	☐ Abacavir	☐ Lamivudine	☐ Emtricitabine
☐ Tenofovir/TAF	☐ Efavirenz	☐ Nevirapine	☐ Etravirine
☐ Rilpivirine	☐ Doravirine	☐ Atazanavir	☐ Darunavir
☐ Fosamprenavir	☐ Lopinavir/R	☐ Nelfinavir	☐ Saquinavir
☐ Maraviroc	☐ Raltegravir	☐ Dolutegravir	☐ Bictegravir

Others not listed:

Patient's allergies:

Is the patient HLA-B*5701 positive? ☐ Yes ☐ No

Has the patient had Mitochondrial Toxicity? ☐ Yes ☐ No

Proposed Optimized Regimen: Trogarzo

Other information to assist reviewers (not required):

PLEASE ATTACH ALL NECESSARY DOCUMENTS.