	Delaware Health & Social Services **Division of Public Health** **Ryan White ADAP Program** **Phone: 302-744-1050** **Fax: 302-661-7226**	Ramsell™

Rukobia (fostemsavir) Prior Authorization Form

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.

☐ **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:**		
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.

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.

For office use only:

Clinical review completed by:		Date:
Outcome:	Approved	Denied

ADAP review completed by:		Date:
Outcome:	Approved	Denied