Egrifta® Prior Authorization Request for WA EIP

FOR PROVIDER USE ONLY

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

(Please Print Clearly)

***PATIENT INFORMATION:**

LAST NAME FIRST NAME

Patient's EIP ID Date of Birth

Most Recent Viral Load :_____Date:_____

Most Recent CD4 Count:_____Date:_____

Current Weight:_____ Current Height:_____

Waist circumference:_____BMI:_____

Please provide supporting documentation for the medical necessity in patients 18 years and older:

- ○ Negative pregnancy test (Pregnancy Category X)
- ○ Current antiretroviral regimen
- ○ No evidence of active malignancy

***DIAGNOSIS DESCRIPTION:**
(ICD-10 CM Code Plus Description):_____

_____

_____

***PHARMACY INFORMATION:**

Pharmacy Name NABP#

Phone Number Fax Number

***PHYSICIAN INFORMATION:**

Last Name First Name

Phone Number Fax Number

DEA Number E-Mail address

Address City Zip Code

*

Signature of pharmacist or physician Date

DRUGS REQUESTED (EIP FORMULARY MEDICATIONS ONLY):

GENERIC NAME	NDC CODE	DIRECTIONS	QUANTITY
Tesamorelin Acetate			

MEDICAL JUSTIFICATION: