Maraviroc (Selzentry™) Prior Authorization Form
FOR PROVIDER USE ONLY
California AIDS Drug Assistance Program (ADAP)
Telephone: 888-311-7632 FAX: 800-848-4241

APPLICATION INFORMATION

This application is required if you are requesting the initial authorization for Maraviroc (Selzentry™) to be covered by the California AIDS Drug Assistance Program (ADAP).

Complete section one (1) for all patients. Complete section two (2) or three (3) as applicable.

Prescriber name and signature must be included.
For information on completing this form, please call the clinical services department: 1-888-311-7632, ext. 2653 or 2635.

Section 1	Patient Last Name:	Patient First Name:
Date of Birth:		ADAP# or SS#:

Section 2 INITIATION OF THERAPY

- **Maraviroc Prior Authorization for patients starting therapy**

☐ Tropism assay results (dated within 90 days) confirm CCR5 mono-tropic HIV co-receptors has been submitted along with this form.

Section 3 CONTINUATION OF THERAPY

- **Maraviroc Prior Authorization for patients currently receiving maraviroc through another payer (i.e. Medi-Cal, private payer, clinical trial)**

☐ This patient is currently on and has a demonstrated virologic response to maraviroc therapy.

Last prescription filled on (date):_____

DATE:	To the best of my knowledge, I certify that the above is accurate and true.	
Prescriber Name:	Prescriber Signature:	
Phone #	Fax #	DEA #
Pharmacy Name:	NABP/NPI #	
Phone #	Fax #	