Selzentry® (maraviroc) Prior Authorization Form

ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

Complete Patient and Physician information (PLEASE PRINT)

STEP 1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:
	Tax ID or NPI #:

If Applicable: Pharmacy Name: ______________________________
Pharmacy Phone: ______________________________

Complete the Clinical Assessment:

STEP 2

Diagnosis	☐ HIV+ w/ evidence of viral replication ☐ CCR5 strain positive ☐ Resistance to other anti-retroviral treatment Which regimens: ______________________	☐ Other (please state):
	☐ HIV-1 strain Topism Assay has been completed* Results (circle one): CCR5+ CXCR4+ Dual-tropic OTHER If Tropism Assay indicates OTHER, please explain: ________________ *Tropism Assay must be completed and results must be attached in order for PA approval. Visit www.trofileassay.com for more information on ordering a Tropism Assay Please indicate concomitant HIV therapy being prescribed: ________________	
Physician Specialty	Please indicate physician specialty:	
Supporting Documentation	Diagnosis: ICD-9 Code #/ Description / J Code (required):	
	Please attach a copy of the prescription or provide ALL of the information below: Selzentry® (maraviroc) Strength ________________ Sig ________________ Qty ________________ Refills ________________	
	Please attach all relevant medical records and test results. **Incomplete forms will not be processed.**	

STEP 3

I certify that the above is correct and accurate to the best of my knowledge (please sign and date).

______________________________ ______________________
Prescriber Signature Date

STEP 4

Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk: 970-248-5034

Name of Person filling out form: ______________________________

Pharmacy Technician initials ______ Date Initiated ________________

Confidentiality Notice:

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03/16/10