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:

Please attach all relevant medical records and test results.

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: ____________________ ____________________ *Note: Selzentry is not recommended in patients with dual/mixed or CXCR4-tropic HIV-1* *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-9/10 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 ____________________	
	We will not process incomplete forms. If we do not receive the completed form & all relevant medical records & test results within 10 calendar days of this request, it will be denied.	

STEP 3

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

____________________ Prescriber Signature

____________________ Date

Confidentiality Notice:

This facsimile transmission (and/or documents accompanying it) may contain confidential information. This information is intended only for the use of the individual(s) named above. If you have received this transmission in error, or cannot identify the recipient for distribution purposes, please notify us immediately at 970-244-7760. Plans underwritten by Rocky Mountain HMO or Rocky Mountain HealthCare Options.

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 ___________________________