



ADAP Prior Authorization Request Form

Use this form to request ADAP prior authorization for **initiation** (not continuation) of therapy for: *enfuvirtide, maraviroc, peginterferon alfa-2a and alfa-2b, ribavirin, abacavir, abacavir-containing medications*

**SOUTH CAROLINA
AIDS Drug
Assistance Program
ADAP**

**Fax the completed form and documentation to ADAP:
803-898-7683**

1.	Date of Request		ADAP Pharmacy Patient ID# <i>If known</i>	SC ADAP Patient ID# <i>If known</i>
2.	Name of Requested Drug(s)			
3.	Patient Information	Last Name	First Name	MI
				Date of Birth
4.	Physician Information <i>(Please print clearly)</i>	Last Name	First Name	MI
		Address	City	State
		Facility/clinic name	Phone # with area code	Fax # with area code
			Clinic phone # with area code	Clinic fax # with area code
5.	Clinical Data: <i>Enter data in chronological order from earliest to most current date</i>	CD4 Count	Date Drawn	Viral Load Value
				Date Drawn
6.	HAART <i>(Highly Active Anti-Retroviral Therapy)</i> History	<input type="checkbox"/> a) Certification: I certify that I have the expertise and experience necessary to prescribe complex HAART regimens for drug resistant strains of HIV.		
		<input type="checkbox"/> b) Certification: I certify that this patient has been prescribed & failed at least two HAART regimens.		
		Physician's Signature:		Date:
	Current/most recent regimen of HAART drugs:			
	New regimen of HAART drugs:			

All above-requested information **MUST** be completed (except for information marked "if known"). For the remaining sections, complete the information for the specific drug requested.

7.	Maraviroc (Selzentry®) <i>Complete this section to request ADAP prior authorization for initiation of maraviroc therapy</i>	<input type="checkbox"/> a) Certification: I certify that recent (within the last 6 months) resistance testing (phenotype or genotype) demonstrates HIV multi-drug resistance and allows the possible addition of other antiretroviral agents. (Copy of resistance testing must be included with this prior authorization request.)
		<input type="checkbox"/> b) Certification: I certify that this patient has CCR5-tropic HIV-1 infection as demonstrated by the results of trofile assay indicating positive CCR5-tropic HIV-1 infection. (Copy of tropism assay must be included with this prior authorization request.)
		<input type="checkbox"/> c) Certification: I agree to accept responsibility to ensure instruction of my patient regarding proper administration of maraviroc by the patient/patient's caregiver, to provide appropriate education regarding dosage and therapy, possible side effects and/or possible adverse events.
		Physician's Signature:
		Date:

8.	Enfuvirtide (Fuzeon®) Complete this section to request ADAP prior authorization for initiation of enfuvirtide therapy	Rationale: Enfuvirtide therapy is indicated for this patient as a result of (e.g., drug resistance, side effects, etc.):
		<input type="checkbox"/> a) Certification: I certify that recent (within last 6 months) resistance testing (phenotype or genotype) demonstrates HIV multi-drug resistance, but shows sensitivity to enfuvirtide and allows possible addition of other antiretroviral agents. IMPORTANT: Include copy of resistance testing with prior authorization request.
		<input type="checkbox"/> b) Certification: I agree to accept responsibility for delivery of enfuvirtide from the ADAP pharmacy or other supplier/distributor, via direct shipment to my office/clinic, for direct dispensing to my patient.
		<input type="checkbox"/> c) Certification: I agree to accept responsibility to ensure instruction of my patient regarding proper administration of enfuvirtide by the patient/patient's caregiver, to provide appropriate education and supplies, and accept responsibility for proper disposal of used sharps/needles into sharps containers and other infection control requirements.
		<input type="checkbox"/> d) Certification: I agree to provide, when notified, all appropriate needlestick exposure management and administer Post-Exposure Prophylaxis (with medications dispensed by the ADAP pharmacy) for any household member who may experience a bona fide exposure from my patient. (HIV needlestick management consultation is available from 803-898-0861 DHEC Division of Acute Disease Epidemiology (DADE) (business hours), 803-690-3756 (DADE pager service), 888-847-0902 (DHEC emergency answering service).)
Physician's Signature: _____ Date: _____		

9.	Peginterferon alfa-2a, (Pegasys®) Peginterferon alfa-2b (PEG-Intron®) Ribavirin (Copegus®, Rebetol®) Complete this section to request ADAP prior authorization for initiation of: 1) peginterferon or 2) ribavirin with peginterferon therapy	<input type="checkbox"/> a) Certification: I certify that I have the expertise and experience necessary to manage patients with HIV-HCV co-infection and prescribe HCV treatments.										
		<input type="checkbox"/> b) Certification: I certify that this patient has HCV co-infection with HIV and has been counseled about HCV therapies, potential cure rates, side effects, self-injection methods, and needle safety and disposal issues. I certify that this patient is a suitable candidate for HCV therapy.										
		<table border="1"> <tr> <td rowspan="5" style="text-align: center; vertical-align: middle;">I certify</td> <td>HCV genotype is:</td> </tr> <tr> <td><input type="checkbox"/> c) Dosage of peginterferon alfa-2a:</td> </tr> <tr> <td><input type="checkbox"/> d) Dosage of peginterferon alfa-2b:</td> </tr> <tr> <td><input type="checkbox"/> e) Dosage of ribavirin:</td> </tr> <tr> <td>Length of therapy (weeks/months) is:</td> </tr> <tr> <td colspan="2">Liver biopsy: patient had a liver biopsy & results show:</td> </tr> <tr> <td colspan="2">Or, no liver biopsy: biopsy was not performed because:</td> </tr> </table>	I certify	HCV genotype is:	<input type="checkbox"/> c) Dosage of peginterferon alfa-2a:	<input type="checkbox"/> d) Dosage of peginterferon alfa-2b:	<input type="checkbox"/> e) Dosage of ribavirin:	Length of therapy (weeks/months) is:	Liver biopsy: patient had a liver biopsy & results show:		Or, no liver biopsy: biopsy was not performed because:	
		I certify		HCV genotype is:								
				<input type="checkbox"/> c) Dosage of peginterferon alfa-2a:								
				<input type="checkbox"/> d) Dosage of peginterferon alfa-2b:								
				<input type="checkbox"/> e) Dosage of ribavirin:								
			Length of therapy (weeks/months) is:									
		Liver biopsy: patient had a liver biopsy & results show:										
		Or, no liver biopsy: biopsy was not performed because:										
<input type="checkbox"/> f) Certification: This patient does not have any psychiatric diagnosis that may be exacerbated by treatment for hepatitis C.												
<input type="checkbox"/> g) Certification: I agree to notify the ADAP pharmacy (800-465-7333) if I prescribe a drug "holiday" from these medications for more than one week's duration, to facilitate coordination of prescribing/delivery schedules and prevent medication wastage.												
<input type="checkbox"/> h) Certification: I agree to accept delivery of these medications from the ADAP pharmacy or other supplier/distributor, via direct shipment to my office/clinic, for direct dispensing to my patient, for the first month of therapy. I understand that the ADAP pharmacy will thereafter ship the medication directly to my patient for the duration of the prescribed therapy unless I order otherwise.												
<input type="checkbox"/> i) Certification: I agree to accept responsibility to ensure instruction of my patient regarding proper administration of these medications by the patient/patient's caregiver, to provide appropriate education and supplies, and accept responsibility for proper disposal of used sharps/needles into sharps containers and other infection control requirements.												
<input type="checkbox"/> j) Certification: I agree to provide, when notified, all appropriate needlestick exposure management and administer Post-Exposure Prophylaxis (with medications dispensed by the ADAP pharmacy) for any household member who may experience a bona fide exposure from my patient. (HIV needlestick management consultation is available from DHEC Division of Acute Disease Epidemiology (DADE) at 803-898-0861 (business hours), 803-690-3756 (DADE pager service), or 888-847-0902 (DHEC emergency answering service).)												
Physician's Signature: _____ Date: _____												

10.	Abacavir, abacavir-containing medications Complete this section to request ADAP prior authorization for initiation of abacavir or abacavir-containing medications	<input type="checkbox"/> a) Certification: I certify that the HLA-B*5701 blood test demonstrated the patient is not at increased risk of abacavir hypersensitivity. IMPORTANT: Copy of HLA-B*5701 testing must be included with this prior authorization request.
		<input type="checkbox"/> b) Certification: I certify that although the patient has <i>not</i> received HLA-B*5701 screening, the patient has been receiving chronic abacavir therapy and tolerates the medication.
		Physician's Signature: _____ Date: _____

**Instructions for Completing DHEC 1596
ADAP Prior Authorization Request Form**

TITLE: ADAP Prior Authorization Request Form

PURPOSE: To provide a uniform system to submit requests for ADAP drugs requiring prior authorization.

COMPLETION OF FORM: The physician prescribing ADAP drugs that require prior authorization must complete the ADAP Prior Authorization Request Form.

FILING AND MECHANICS: The completed form and any accompanying documentation must be faxed to ADAP at fax number 803-898-7683. The DHEC HIV/STD Division Medical Consultant reviews the information to determine ADAP approval or denial of the drug for the ADAP client. The form is retained in ADAP confidential files for 10 years.

EXPLANATION AND DEFINITION: The form is to be used by physicians prescribing drugs that require prior authorization when initially prescribed for ADAP clients.

INSTRUCTIONS:

Section 1 **Date of Request:** Enter date of request.
ADAP Pharmacy Patient ID# if known: Enter the ADAP Pharmacy patient ID#, if known.
SC ADAP Patient ID# if known: Enter the SC ADAP patient ID#, if known.

Section 2 **Name of Requested Drug(s):** Enter name of drug(s) for which prior authorization is being requested.

Section 3 **Patient Information**
Last Name: Enter last name of patient.
First Name: Enter first name of patient.
MI: Enter middle initial of patient.
Date of Birth: Enter date of birth of patient.

Section 4 **Physician Information**
Last Name: Enter last name of physician.
First Name: Enter first name of physician.
MI: Enter middle initial of physician.
Phone # with area code: Enter phone number with area code where physician may be contacted by ADAP if there are questions regarding the information submitted.
Address: Enter address of physician.
City: Enter city in which physician's practice is located.
State: Enter state in which physician's practice is located.
Fax # with area code: Enter fax number with area code of physician.
Facility/clinic name: Enter name of facility/clinic where physician practices or where patient was seen.
Clinic phone # with area code: Enter clinic phone number with area code where physician may be contacted by ADAP if there are questions regarding the information submitted.

Section 5 **Clinical Data** – Enter data in chronological order, from earliest to most current date.
CD4 Count: Enter the patient's CD4 count, from earliest to latest (most current) date.
Date Drawn: Enter the date drawn for the corresponding CD4 count.
Viral Load Value: Enter the patient's viral load value, from earliest to latest (most current) date.
Date Drawn: Enter the date drawn for the corresponding viral load value.

- Section 6** **HAART History** –Enter information relevant to patient’s Highly Active Anti-Retroviral Therapy.
- a), b) **Certification:** Review statement and if it is factual, mark the check-off box to indicate the physician’s certification.
Physician’s Signature: Enter the physician’s signature to indicate certification of HAART history.
Date: Enter date of physician’s signature.
Current/most recent regimen of HAART drugs: Enter the names of the HAART drugs currently prescribed for the patient.
New regimen of HAART drugs: Enter the names of the HAART drugs that will be prescribed for the patient.
- Section 7** **Maraviroc (Selzentry®)** – Complete this section to request ADAP prior authorization for initiation of maraviroc therapy.
- a), b), c) **Certification:** Review statement and if factual, mark the check-off box to indicate physician’s certification. Additionally, it is important to include a copy of the resistance testing, tropism assay.
Physician’s Signature: Enter the physician’s signature to indicate certification of enfuvirtide information.
Date: Enter date of physician’s signature.
- Section 8** **Enfuvirtide (Fuzeon®)** – Complete this section to request ADAP prior authorization for initiation of enfuvirtide therapy.
- a), b), c), d) **Rationale:** Enter rationale for prescribing enfuvirtide therapy for the patient.
Certification: Review statement and if factual, mark the check-off box to indicate physician’s certification. Additionally, it is important to include a copy of the resistance testing.
Physician’s Signature: Enter the physician’s signature to indicate certification of enfuvirtide information.
Date: Enter date of physician’s signature.
- Section 9** **Peginterferon alfa-2a (Pegasys®)** Complete this section to request ADAP prior authorization
Peginterferon alfa-2b (PEG-Intron®) for initiation of peginterferon or ribavirin with peginterferon
Ribavirin (Copegus®, Rebetol®) therapy.
- a), b) **Certification:** Review statement and if factual, mark the check-off box to indicate physician’s certification.
HCV genotype: Enter the patient’s HCV genotype.
- c), d), e) **Dosage:** Enter the dosage of the prescribed drug.
Length of therapy: Enter the length of therapy (weeks, months) for the prescribed drug.
Liver biopsy: Enter the results of the patient’s liver biopsy.
No liver biopsy: Enter the reason for not performing a liver biopsy.
- f), g), h), i), j) **Certification:** Review statement and if factual, mark the check-off box to indicate physician’s certification.
Physician’s Signature: Enter the physician’s signature to indicate certification of information.
Date: Enter date of physician’s signature.
- Section 10** **Abacavir or abacavir-containing medications** – Complete this section to request ADAP prior authorization for initiation of abacavir or abacavir-containing medications.
- a), b) **Certification:** Review statement and if factual, mark the check-off box to indicate physician’s certification. Additionally, it is important to include a copy of the HLA-B*5701 testing.
Physician’s Signature: Enter the physician’s signature to indicate certification of enfuvirtide information.
Date: Enter date of physician’s signature.