Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Selzentry

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Florida at **1-855-799-2554**.
When conditions are met, we will authorize the coverage of Selzentry.
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Selzentry (maraviroc)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Is Selzentry being prescribed at one of the following doses? Y N
   - 150mg twice daily - when given with strong CYP3A inhibitors (with or without CYP3A inducers) including PIs (except tipranavir/ritonavir), delavirdine
   - 300mg twice daily - when given with NRTIs, tipranavir/ritonavir, nevirapine, and other drugs that are not strong CYP3A inhibitors or CYP3A inducers
   - 600mg twice daily - when given with CYP3A inducers including efavirenz (without a strong CYP3A inhibitor)
   -

2.	Has tropism testing been performed? Please submit a copy of the assay.	Y	N
3.	Is the patient 16 years of age or older?	Y	N
4.	Is the patient treatment-experienced? [If no, then skip to question 6.]	Y	N
5.	Does the patient have current lab results for CD4 count, Viral load, and Resistance testing?Please submit lab results. [No further questions.]	Y	N
6.	Is the patient treatment-naïve?	Y	N
7.	Does the patient have current lab results for CD4 count and Viral load? Please submit lab results.	Y	N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date