Georgia ADAP Application for Symtuza Prior Approval

DATE OF REQUEST:	

CLIENT INFORMATION:			
Client Name (Last, First, M):			
District/Clinic where the client is seen:			
Client/Caregiver:			
1) Patient is willing to take (or caregiver to administer) medications as directed.	☐ Yes	☐ No	
2) Patient has prior evidence of adherence to therapy and medical care; and prescriber has reasonable expectation that adherent behavior will continue.	☐ Yes	☐ No	
3) Patient's home has sufficient storage at the proper temperature.	☐ Yes	☐ No	

Prescriber Information:			
Provider Name (Last, First, M):		Phone:	
Email:		Signature:	

Fiscal Request Determination:			
Date Received:		Date of Decision:	
☐ Request approved	☐ Request Denied		
Approver (Last, First, M):			
Phone:		Email:	
Approver Signature:			

Comments/Additional Information or Instructions:

Provider/Prescriber Guidelines:
Patient must have a repeat HIV viral load within 2-8 weeks from medication initiation and if the HIV RNA is detectable at 2-8 weeks, repeat testing every 4-8 weeks until viral load is suppressed to <200 copies/mL.
If CD4 and/or viral load have not improved, clinical improvement (or clinically stable if condition was worsening before) must be documented for continuation of the new regimen.
The prescriber must review the state guidelines and/or restrictions concerning the use of these medications to determine that the patient qualifies.
The prescriber should be an experienced HIV/AIDS provider or should consult with a specialist and must have sufficient office/clinic capability to provide patient education and monitoring.
Guidelines: http://aidsinfo.nih.gov/guidelines