Georgia ADAP Application for Prior Approval Medications

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

DRUGS REQUESTED & REQUIRED INFORMATION:
Please complete the corresponding section for the specific drugs requested and check the appropriate boxes or supply the response/ supporting documentation.

☐ **Fuzeon (Enfuviritide)**
1) Current antiretroviral regimen:
2) Please attach copies of the most recent viral load, CD4 count and all available resistance testing.
3) Proposed optimized regimen:
4) Does the client have a history of moderate to severe adverse events/ intolerances/ allergies to medications? ☐ Yes ☐ No
o If yes, what medications?
o Describe the reaction:
5) Does the client have a history of enrollment in a recent study or Expanded Access Program? ☐ Yes ☐ No o If yes, please provide documentation.
If the client's regimen includes Fuzeon, Georgia ADAP recommends *completing a "Fuzeon Nurse Connections" enrollment form to arrange for a home visit from a Fuzeon Nurse Educator to help the client to become confident in their ability to reconstitute and inject Fuzeon. The form is available at www.fuzeon.com or via phone at 877-4FUZEON (877-438-9366)*

☐ **Selzentry (Maraviroc)**
1) Current antiretroviral regimen:
2) Please attach copies of the most recent viral load, CD4 count, tropism assay test and all available resistance testing.
3) Proposed optimized regimen:
4) Does the client have a history of moderate to severe adverse events/ intolerances/ allergies to medications? ☐ Yes ☐ No

o If yes, what medications?
o Describe the reaction:

☐ **Videx (Didanosine)**
1) Current antiretroviral regimen:
2) Length of time on current regimen:
3) Reason for continuing or adding Videx to the regimen:
4) Please attach copies of most recent viral load, CD4 count and all available resistance testing.

☐**Zerit (Stavudine)**
1) Current antiretroviral regimen:
2) Length of time on current regimen:
3) Reason for continuing or adding Zerit to the regimen:
4) Please attach copies of most recent viral load, CD4 count and all available resistance testing.

Please select requested regimen from the options listed below (Ribavirin will be weight based):
☐**Harvoni (Ledipasvir-sofosbuvir)**
☐**Daklinza (Daclatasvir) plus Sovaldi (Sofosbuvir)** ☐**with Ribavirin or** ☐**without Ribavirin**
☐**Sovaldi (Sofosbuvir) plus Ribavirin**
☐**VIEKIRA PAK** ☐**with Ribavirin or** ☐**without Ribavirin**
☐**Technivie** ☐**with Ribavirin or** ☐**without Ribavirin**
☐**Zepatier** ☐**with Ribavirin or** ☐**without Ribavirin**

Requested Course of Therapy: ☐ **12 weeks,** ☐ **16 weeks, or** ☐ **24 weeks**

1) Client is an active and stable ADAP client. (Requirement) ☐ Yes ☐ No					
2) Client Weight:		3) Client Age:		4) Client Sex:	
5) Current antiretroviral regimen:					
6) List of current non-HIV medications:					
5) Does the client have a history of moderate to severe adverse events/ intolerances/ allergies to medications? ☐ Yes ☐ No					

o If yes, what medications?
o Describe the reaction:
7) Please attach copies of the most recent lab work: HIV viral load, CD4 count, CMP, CBC, PT/INR, pregnancy test (if woman of child bearing age), Hepatitis C antibody, Hepatitis C viral load, NS5A resistance-associated polymorphism test (for Zepatier: genotype 1a), Hepatitis C genotype/subtype, i.e. 1a, 1b, etc.
8) Hepatitis C stage: ☐0 ☐1 ☐2 ☐3 ☐4 ☐compensated cirrhosis ☐decompensated cirrhosis
o Please check the lab performed within the last 12 months and include a copy: ☐ Liver biopsy ☐ FIB-4 Calculation ☐ Non-Invasive Biomarker Testing
9) Please attach the client's MELD or Child-Pugh score.
10) Does the client have a history of Hepatitis C treatment? ☐Yes ☐ No
o If yes, what treatment?
11) The requesting provider is asking for the State Medical Advisor to make the treatment recommendation. ☐ Yes ☐ No

PROVIDER/PRESCRIBER GUIDELINES:
• Patient must have a repeat HIV viral load and CD4 counts performed 12 and 24 weeks after initiation of the regimen to assess effectiveness.
• 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 / https://dph.georgia.gov/nurse-protocols
• Hepatitis C Guidelines: http://www.hcvguidelines.org/
• Georgia Department of Public Health Hepatitis C Testing Tool Kit: https://dph.georgia.gov/sites/dph.georgia.gov/files/related_files/site_page/ADES_Hepatitis_C_Testing_Toolkit_for_Primary_Care_Providers_in_Georgia.pdf

PRESCRIBER INFORMATION:			
Prescriber Name (Last, First, M):			
Phone:		Email:	
Prescriber Signature:			

REQUEST DETERMINATION:			
Date Received:		Date of Decision:	
☐ Request Approved ☐ Request Denied			
Medical Advisor (Last, First, M):			
Phone:		Email:	
Prescriber Signature:			

Comments/ Additional Information or Instructions: