



If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Medicaid ID Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date of Birth:

				-					-										
--	--	--	--	---	--	--	--	--	---	--	--	--	--	--	--	--	--	--	--

Gender: Male Female

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

NPI Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Phone Number:

				-					-										
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Fax Number:

				-					-										
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DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name:

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Member's First Name:

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DIAGNOSIS AND MEDICAL INFORMATION

Biktarvy® – to receive a ONE (1) year approval for this drug, complete the following questions.

1. Does the member have a diagnosis of human immunodeficiency virus (HIV)? **AND**
 Yes No
2. Does the member weigh at least 25 kg? **AND**
 Yes No
3. Has the member been tested for hepatitis B infection prior to initiation of therapy? **AND**
 Yes No
4. Does the member have a creatinine clearance (CrCl) ≥ 30 mL/min within the last 30 days? **AND**
 Yes No
5. Is there confirmation that the member does **not** have severe hepatic impairment? **AND**
 Yes No
6. Is there confirmation that the member is **not** on other antiretroviral treatment (ART) medications?
AND
 Yes No
7. Is there confirmation that the member is **not** on concurrent dofetilide or rifampin?
 Yes No

INFORMATIONAL:

Quantity Limit = 34 tablets/34 days

Prescriber Signature (Required)

Date

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the SA process.

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:
Magellan Medicaid Administration / ATTN: MAP
11013 W. Broad Street, Glen Allen, VA 23060

Virginia Medicaid Pharmacy Services Portal: <http://www.virginiamedicaidpharmacyservices.com>

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