

**Ryan White Program
Service Delivery Guidelines
Fiscal Year 2011-2012
(Year 21)**

**Section V –
Letters of Nutritional Assessment,
Medical Necessity, and
Prior Authorization**



*Miami-Dade County
Office of Grants Coordination*

**RYAN WHITE PROGRAM NUTRITIONAL ASSESSMENT LETTER FOR
FOOD BANK SERVICES**
(THIS DOCUMENT IS TO BE COMPLETED BY AN INDEPENDENT PHYSICIAN
OR A REGISTERED DIETITIAN
NOT ASSOCIATED WITH THE PART A FOOD BANK PROVIDER.)

TO BE COMPLETED BY PHYSICIAN

Date: _____

As the **primary medical caretaker** for _____, who has a diagnosis of _____, it is my professional opinion that he/she requires food bank assistance.

Please specify frequency:

- Weekly Monthly

Please specify maximum number of additional food bank visits (occurrences) recommended within a twelve-month period, which starts with the date of the client's first visit to the food bank (first occurrence):

- One visit Two visits Three visits

This assistance will maintain the patient's health by providing a balanced, adequate diet, which the patient is currently not receiving.

Physician Signature _____ Name _____

Print MEO# _____

OR

TO BE COMPLETED BY REGISTERED DIETITIAN

Date: _____

As a **registered dietitian** who has completed an assessment of _____, who has a diagnosis of _____, it is my professional opinion that he/she requires food bank assistance.

Please specify frequency:

- Weekly Monthly

Please specify maximum number of additional food bank visits (occurrences) recommended within a twelve-month period, which starts with the date of the client's first visit to the food bank (first occurrence):

- One visit Two visits Three visits

This assistance will maintain the patient's health by providing a balanced, adequate diet, which the patient is currently not receiving.

RD Signature _____ Name _____

Print

RD License # _____

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Rev. 3/1/09

**RYAN WHITE PROGRAM
LETTER OF MEDICAL NECESSITY FOR HOME DELIVERED MEALS
(PHYSICIAN CERTIFICATION)**

As the primary physician for _____, CIS # _____, it is my professional opinion that he/she qualifies for home delivered meals assistance because he/she meets the conditions required for this service (as indicated below).

I hereby certify that:

1. This patient has the following diagnosis (check one):

- AIDS
- HIV+ symptomatic, with the following condition that makes home delivered meals necessary:
(please specify condition and check one of the following: _____)
_____ Temporary condition (specify time period _____)
_____ Permanent condition

AND

2. This patient meets the following Project AIDS Care (PAC) Waiver condition for home delivered meals (check as appropriate):

- The patient is homebound*; functionally impaired**; and no other person in the patient's household is able to prepare meals, or the person who usually prepares meals is temporarily absent or unable to manage meal preparation.
- A therapeutic diet is authorized for this patient that can only be implemented through home delivered meals.

AND

3. This patient requires _____ home delivered meals per day, from the date of my signature, for a period of (check one):

- (# of meals)
- 1 MONTH 2 MONTHS 3 MONTHS

*Definitions - * Homebound: The individual is confined to his or her home for any period of time and is unable to leave the residence without assistance from another person. The homebound person must have no other means of obtaining meals.*

*** Functionally impaired: The patient has difficulty performing one or more activities of daily living such as bathing, dressing, walking, getting to the toilet, or eating. The functionally impaired person may not be capable of preparing meals.*

Sincerely,

Physician's Signature

Date

Physician's Name (please print)

Physician's Florida Medical License Number

Agency/Clinic/Practice Name

(_____)_____
Physician's Telephone Number

Agency/Clinic/Practice Street Address

Agency/Clinic/Practice City, State, Zip

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Rev. 3/1/09

**RYAN WHITE PROGRAM
LETTER OF MEDICAL NECESSITY FOR
ANTIRETROVIRAL PHENOTYPE RESISTANCE ASSAYS FOR EXPERIENCED PATIENTS
COVERAGE IS LIMITED TO A MAXIMUM OF ONE PHENOTYPE IN ANY CONSECUTIVE 12-MONTH PERIOD.
*(NOT REQUIRED FOR VIRTUAL PHENOTYPE TESTS)***

Date: _____

As the primary medical caretaker for _____ it is my considered opinion that he/she requires HIV phenotypic resistance testing. The following criteria have been met:

1. The patient at any time in the past has failed two (2) or more antiretroviral (ARV) regimens;
2. Results of at least one, preferably more, prior genotype(s) must be available in the chart and Resistance to two or more drugs per class in at least two classes of ARVs is present on prior genotype(s);

AND ONE OF THE FOLLOWING (check-off the appropriate condition below):

___ Prior genotype(s) show(s) resistance to at least 2 PIs other than ritonavir and use of a PI is being considered;

OR

___ Lopinavir/ritonavir is being considered in a PI-experienced patient with four or more mutations associated with resistance to lopinavir/ritonavir on a prior genotype;

OR

___ Four or more mutations at codons associated with PI cross-resistance are present;

OR

___ M184V mutation is present in the presence of 3 or more NRTI-associated mutations (NAMs);

OR

___ K65R mutation is present, or other mutations associated with NRTI cross-resistance (69 insertion complex or 151 complex);

OR

___ Rescue ARV regimens guided by results of two or more prior genotypes have failed to suppress viral replication, whether mutations present or not, and the patient has been determined to be adherent on re-evaluation. (Requires a minimum of two prior genotypes.)

I understand HIV phenotypic resistance testing for experienced patients may only be ordered under the following conditions:

1. The above criteria have been met and are fully documented in the patient's medical record;
2. Adherence has been discussed with the patient on an on-going basis as part of his/her medical treatment, and it has been determined that the patient is fully adherent with his/her current ART regimen;
3. The patient's plasma HIV RNA (viral load) at the time of testing must be at least 1000 co/ml within the past month (attach copy to letter of medical necessity);
4. The patient must be on antiretroviral medications at the time of testing.

Sincerely,

_____, M.D.

Print Physician's name

Florida Medical License # (MEO#)

Patient's 10 digit Medicaid # (if applicable)

Patient's CIS # (assigned by the Ryan White Program Service Delivery Information System)

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RYAN WHITE PROGRAM
Letter of Medical Necessity to Accompany Prescription for Tipranavir (Aptivus®)

Date: _____

As the prescribing healthcare provider for _____, I consider it to be medically necessary to add Tipranavir (Aptivus®) to this patient's antiretroviral regimen.

In addition, I hereby certify that the following criteria have been met:

1. The patient has failed treatment with Lopinavir/ritonavir (Kaletra®) and all three classes of antiretrovirals;

-AND-

2. I have fully discussed all issues and consequences related to non-adherence with the patient.

Sincerely,

_____, M.D.

Print Physician's name

Florida medical license # (MEO#)

Patient's 10 digit Medicaid # (if applicable)

Patient's CIS # (assigned by the Ryan White Program Service Delivery Information System)

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Rev. 3/1/09

RYAN WHITE PROGRAM
Letter of Medical Necessity to Accompany Prescription for
Enfuvirtide (Fuzeon®)

Date: _____

As the primary medical provider for _____, I consider it to be medically necessary to add Enfuvirtide (Fuzeon®) to this patient's antiretroviral regimen.

This patient has been on Enfuvirtide (Fuzeon®) through another funding source but this funding source is no longer available. This condition necessitates Ryan White Program coverage for continuity of care.

In addition, the patient meets one (1) of the following (check-off the appropriate criteria below):

The patient is eligible for the AIDS Drug Assistance Program (ADAP) and there is a completed application pending approval. A new prescription is allowed for a maximum of **60 days** and no refill authorizations are accepted.

-OR-

The patient is not eligible for ADAP and must be covered under the Ryan White Program pending another payment source. A new prescription is allowed for a maximum of **90 days** and no refill authorizations are accepted.

_____, M.D.

Print M.D.'s name

Florida medical license # (MEO#)

Patient's 10 digit Medicaid # (if applicable)

Patient's CIS # (assigned by the Ryan White Program Service Delivery Information System)

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Rev. 3/1/09

RYAN WHITE PROGRAM NUTRITIONAL SUPPLEMENTS
Letter of Medical Necessity for Supplementation in ADULTS

Date: _____

As the primary medical caretaker for _____, who has a diagnosis of HIV/AIDS, it is my considered opinion that he/she requires enteric nutritional supplements.

I believe that nutritional supplements are medically indicated in this case and I have referred this patient for a professional Nutritional Assessment by a Registered Dietitian/Nutritionist.

I understand enteral nutrition must be evaluated by a Dietitian/Nutritionist every _____. (Please indicate period of time for nutritional re-evaluation. Number of refills authorized cannot exceed this period of time.)

Sincerely,

_____, M. D./ D.O./ ARNP/ PA-C

SIGNATURE

(Physician, Nurse Practitioner or Physician Assistant)

PRINT NAME

(Physician, Nurse Practitioner or Physician Assistant)

Florida Medical License #

PRINT NAME

(Registered Dietitian/Nutritionist)

SIGNATURE

(Registered Dietitian/Nutritionist)

Dietitian/Nutritionist Florida License #

Nutrition Products Available Through the Ryan White Program

Physician/ Nurse Practitioner/ Physician Assistant/ Dietitian/Nutritionist, please indicate preferred product, flavor, number of servings recommended and number of refills authorized. (Dietitian/Nutritionist, please refer to the Criteria for Dispensing Nutritional Supplements FORM for patient's nutritional assessment on back page.)

Please document patient's: Height: _____ Weight: _____ Lbs Kgs IBW/UBW: _____ Lbs Kgs

NOTE: 1 Serving = 2 Scoops

- Progain Powder - ___ No. of **SERVINGS per DAY** Vanilla Chocolate
(HIGH calorie product)
Number of Refills Authorized _____
(Number of refills authorized cannot exceed period of time for re-evaluation by nutritionist/dietitian as indicated above)
- IgG Pure - ___ No. of **SERVINGS per DAY** (Only natural flavor available)
(LOW calorie product)
Number of Refills Authorized _____
(Number of refills authorized cannot exceed period of time for re-evaluation by nutritionist/ dietitian as indicated above)

Please note: If the patient is on MEDICAID, please refer to the MEDICAID Medical Necessity Request Letter.

Patient's 10 digit MEDICAID Number: _____

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**RYAN WHITE PROGRAM
CRITERIA FOR DISPENSING NUTRITIONAL SUPPLEMENTS**

The following are potential situations where commercial nutritional supplements could be considered medically indicated.

Patient must meet at least two (2) criteria listed below.

(Consultation with a Registered Dietitian/Nutritionist for nutritional assessment and a Letter of Medical Necessity are required.)

Please check all that apply:

- Current body weight < 10% IBW/UBW
- Weight loss of:
 - 5% of the initial/baseline weight over the past month -OR-
 - 7.5% over the past 3 months -OR-
 - 10% weight loss within the last 6 months
- Body Cell Mass (BCM) < 40% (MALES) or BCM < 35% (FEMALE) of IBW
- Body Mass Index (BMI) < 20
- Recent illness/hospitalization that will interfere with patient's ability to consume or tolerate adequate non-supplemental nutrition
- Diarrhea/malabsorption with > 3 large, liquid stools/day
- Dysphagia and/or odonyphagia where commercial supplements are the only source of nutrition tolerated
- Serum albumin < 3.5 g/dl
- Failure to gain/maintain weight in the past when following a dietary regimen to promote weight gain
- Inadequate living conditions or inability to buy/prepare meals
- Inability to understand and or follow nutritional recommendations

NUTRITIONAL PLAN FOR SUPPLEMENTS

I. INITIAL Consultation: Date: _____ Weight: _____

Patient assessed/instructed by Registered Dietitian/Nutritionist: **(Please check the appropriate box)**

- Nutritional supplements **recommended** Nutritional supplements **NOT** recommended

II. FOLLOW-UP Visit: Date: _____ Weight: _____

Patient re-assessed for progress: **(Please check the appropriate box)**

- Nutritional supplements **continued** Nutritional supplements **discontinued**

III. ADDT'L FOLLOW-UP Visit: Date: _____ Weight: _____

Patient re-assessed for progress: **(Please check the appropriate box)**

- Nutritional supplements **continued** Nutritional supplements **discontinued**

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Rev. 3/1/09

RYAN WHITE PROGRAM
Letter of Medical Necessity
for Roxicodone (Oxycodone) and Percocet (Oxycodone/APAP)

Date: _____

As the primary care physician treating _____ and in accordance with F.A.C. 64B8-9.013¹ it is my considered opinion that (check one of the following)

Roxicodone (Oxycodone)

Percocet (Oxycodone/APAP) 5/325 *generic only*

is medically necessary for this patient.

The patient's diagnosis related to the reason for prescribing this medication is _____.
The above medication will be prescribed for _____ (length of time) at a strength of _____ with a frequency of _____ (e.g. bid).

- I have documented that other pain medications have been used and have failed or were not tolerated.
- I have discussed the issue of dependency with the patient.

I attest the above conditions have been met and are fully documented in the patient's medical record.

Sincerely,

_____, M.D./D.O.

Print M.D./D.O. name

Florida Medical License # (MEO#)

Patient's 10 Digit Medicaid # (if applicable)

Patient's CIS # (ID number assigned by the Ryan White Program Service Delivery Information System)

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¹ Florida Administrative Code 64B8-9.013 Standards for the Use of Controlled Substances for the Treatment of Pain. Specific Authority Florida Statute 458.309 and 458.331.

64B8-9.013 Standards for the Use of Controlled Substances for the Treatment of Pain.

(1) Pain management principles.

(a) The Board of Medicine recognizes that principles of quality medical practice dictate that the people of the State of Florida have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain. The Board encourages physicians to view effective pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially important for patients who experience pain as a result of terminal illness. All physicians should become knowledgeable about effective methods of pain treatment as well as statutory requirements for prescribing controlled substances.

(b) Inadequate pain control may result from physicians' lack of knowledge about pain management or an inadequate understanding of addiction. Fears of investigation or sanction by federal, state, and local regulatory agencies may also result in inappropriate or inadequate treatment of chronic pain patients. Physicians should not fear disciplinary action from the Board or other state regulatory or enforcement agencies for prescribing, dispensing, or administering controlled substances including opioid analgesics, for a legitimate medical purpose and that is supported by appropriate documentation establishing a valid medical need and treatment plan. Accordingly, these standards have been developed to clarify the Board's position on pain control, specifically as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.

(c) The Board recognizes that controlled substances, including opioid analgesics, may be essential in the treatment of acute pain due to trauma or surgery and chronic pain, whether due to cancer or non-cancer origins. The medical management of pain including intractable pain should be based on current knowledge and research and includes the use of both pharmacologic and non-pharmacologic modalities. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity and duration of the pain. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.

(d) The Board of Medicine is obligated under the laws of the State of Florida to protect the public health and safety. The Board recognizes that inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Physicians should be diligent in preventing the diversion of drugs for illegitimate purposes.

(e) The Board will consider prescribing, ordering, administering, or dispensing controlled substances for pain to be for a legitimate medical purpose if based on accepted scientific knowledge of the treatment of pain or if based on sound clinical grounds. All such prescribing must be based on clear documentation of unrelieved pain and in compliance with applicable state or federal law.

(f) Each case of prescribing for pain will be evaluated on an individual basis. The Board will not take disciplinary action against a physician for failing to adhere strictly to the provisions of these standards, if good cause is shown for such deviation. The physician's conduct will be evaluated to a great extent by the treatment outcome, taking into account whether the drug used is medically and/or pharmacologically recognized to be appropriate for the diagnosis, the patient's individual needs including any improvement in functioning, and recognizing that some types of pain cannot be completely relieved.

(g) The Board will judge the validity of prescribing based on the physician's treatment of the patient and on available documentation, rather than on the quantity and chronicity of prescribing. The goal is to control the patient's pain for its duration while effectively addressing other aspects of the patient's functioning, including physical, psychological, social, and work-related factors. The following standards are not intended to define complete or best practice, but rather to communicate what the Board considers to be within the boundaries of professional practice.

(2) Definitions.

(a) Acute Pain. For the purpose of this rule, "acute pain" is defined as the normal, predicted physiological response to an adverse chemical, thermal, or mechanical stimulus and is associated with surgery, trauma, and acute illness. It is generally time-limited and is responsive to opioid therapy, among other therapies.

(b) Addiction. For the purpose of this rule, "addiction" is defined as a neurobehavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Addiction may also be referred to by terms such as "drug dependence" and "psychological dependence." Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.

(c) Analgesic Tolerance. For the purpose of this rule, “analgesic tolerance” is defined as the need to increase the dose of opioid to achieve the same level of analgesia. Analgesic tolerance may or may not be evident during opioid treatment and does not equate with addiction.

(d) Chronic Pain. For the purpose of this rule, “chronic pain” is defined as a pain state which is persistent.

(e) Pain. For the purpose of this rule, “pain” is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

(f) Physical Dependence. For the purpose of this rule, “physical dependence” on a controlled substance is defined as a physiologic state of neuro-adaptation which is characterized by the emergence of a withdrawal syndrome if drug use is stopped or decreased abruptly, or if an antagonist is administered. Physical dependence is an expected result of opioid use. Physical dependence, by itself, does not equate with addiction.

(g) Pseudoaddiction. For the purpose of this rule, “pseudoaddiction” is defined as a pattern of drug-seeking behavior of pain patients who are receiving inadequate pain management that can be mistaken for addiction.

(h) Substance Abuse. For the purpose of this rule, “substance abuse” is defined as the use of any substances for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.

(i) Tolerance. For the purpose of this rule, “tolerance” is defined as a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect, or a reduced effect is observed with a constant dose.

(3) Standards. The Board has adopted the following standards for the use of controlled substances for pain control:

(a) Evaluation of the Patient. A complete medical history and physical examination must be conducted and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

(b) Treatment Plan. The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

(c) Informed Consent and Agreement for Treatment. The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient, or with the patient’s surrogate or guardian if the patient is incompetent. The patient should receive prescriptions from one physician and one pharmacy where possible. If the patient is determined to be at high risk for medication abuse or have a history of substance abuse, the physician should employ the use of a written agreement between physician and patient outlining patient responsibilities, including, but not limited to:

1. Urine/serum medication levels screening when requested;
2. Number and frequency of all prescription refills; and
3. Reasons for which drug therapy may be discontinued (i.e., violation of agreement).

(d) Periodic Review. At reasonable intervals based on the individual circumstances of the patient, the physician should review the course of treatment and any new information about the etiology of the pain. Continuation or modification of therapy should depend on the physician’s evaluation of the patient’s progress. If treatment goals are not being achieved, despite medication adjustments, the physician should reevaluate the appropriateness of continued treatment. The physician should monitor patient compliance in medication usage and related treatment plans.

(e) Consultation. The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder requires extra care, monitoring, and documentation, and may require consultation with or referral to an expert in the management of such patients.

(f) Medical Records. The physician is required to keep accurate and complete records to include, but not be limited to:

1. The medical history and physical examination, including history of drug abuse or dependence, as appropriate;
2. Diagnostic, therapeutic, and laboratory results;
3. Evaluations and consultations;

4. Treatment objectives;
 5. Discussion of risks and benefits;
 6. Treatments;
 7. Medications (including date, type, dosage, and quantity prescribed);
 8. Instructions and agreements; and
 9. Periodic reviews. Records must remain current and be maintained in an accessible manner and readily available for review.
- Records must remain current and be maintained in an accessible manner and readily available for review.

(g) Compliance with Controlled Substances Laws and Regulations. To prescribe, dispense, or administer controlled substances, the physician must be licensed in the state and comply with applicable federal and state regulations. Physicians are referred to the Physicians Manual: An Informational Outline of the Controlled Substances Act of 1970, published by the U.S. Drug Enforcement Agency, for specific rules governing controlled substances as well as applicable state regulations.

Specific Authority 458.309(1), 458.331(1)(v) FS. Law Implemented 458.326, 458.331(1)(g), (l), (v) FS. History--New 12-21-99, Amended 11-10-02, 10-19-03.

RYAN WHITE PROGRAM
Letter of Medical Necessity to Accompany a Prescription for
Maraviroc (Selzentry ®)

Date: _____

As the primary care physician treating _____, I consider it medically necessary to add Maraviroc (Selzentry) to this patient's antiretroviral regimen which will contain the following two other active agents: _____ and _____.

I certify that the following criteria have been met:

1. The patient has been screened for ADAP and has been found ineligible and must be covered under the Ryan White Program pending another payment source;
2. I have fully discussed all issues and consequences related to non-adherence with the patient;
3. There is evidence of ARV resistance, intolerance and/or lack of patient acceptability to reasonable alternatives resulting in inability to fully suppress HIV utilizing other regimens;
4. The patient has had a Trofile Co-Receptor Tropism Assay showing CCR5 mono-tropism (copy attached); and
5. I have reviewed the patient background and antiretroviral regimen and the Maraviroc dosage is appropriate.

Sincerely,

_____, M.D./D.O.

Print M.D./D.O. name

Florida medical license # (MEO#)

Patient's 10 digit Medicaid # (if applicable)

Patient's CIS # (assigned by the Ryan White Program Service Delivery Information System)

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Rev. 3/1/2009

RYAN WHITE PROGRAM
Letter of Medical Necessity for Sporanox (Itraconazole)

Date: _____

As the primary care physician treating _____, I consider it medically necessary to prescribe Sporanox (Itraconazole). The medication will be utilized to treat **ONLY** one of the following two conditions (please check one box):

	Histoplasmosis
	Aspergillosis

The diagnosis above is fully documented in the patient's medical record.

Sincerely,

_____, M.D./D.O.

Print M.D./D.O. name

Florida medical license # (MEO#)

Patient's 10 digit Medicaid # (if applicable)

Patient's CIS # (assigned by the Ryan White Program
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RYAN WHITE PROGRAM
Letter of Medical Necessity for the Trofile Co-Receptor Tropism Assay required to prescribe Maraviroc (Selzentry ®)

Date: _____

As the primary care physician treating _____, I intend to add Maraviroc (Selzentry) to this patient's antiretroviral regimen which will contain the following two other active agents: _____ and _____.

I certify that the following criteria have been met:

1. The patient has been screened for ADAP and has been found ineligible and must be covered under Ryan White Part A pending another payment source;
2. There is evidence of ARV resistance, intolerance and/or lack of patient acceptability to reasonable alternatives resulting in inability to fully suppress HIV utilizing alternative regimens;

I understand the Trofile Co-Receptor Tropism Assay may only be ordered under the following conditions:

1. The above criteria have been met and are fully documented in the patient's medical record;
2. Adherence has been discussed with the patient on an on-going basis as part of his/her medical treatment, and it has been determined that the patient is satisfactorily adherent with his/her current ART regimen;
3. The patient's plasma HIV RNA (viral load) at the time of testing is at least 1,000 co/ml within the past month (attach copy of viral load to letter of medical necessity); and
4. Patient does not have a history of dual/mixed tropism.

Sincerely,

_____, M.D./D.O.

Print M.D./D.O. name

Florida medical license # (MEO#)

Patient's 10 digit Medicaid # (if applicable)

Patient's CIS # (assigned by the Ryan White Program Service Delivery Information System)

Please note: All questions should be addressed to Ms. Theresa Fiaño, Assistant Director, Office of Grants Coordination, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.).

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**RYAN WHITE PROGRAM
Prior Authorization Form for Neupogen® (Filgrastim)**

Recipient's Full Name: _____ Date of Birth: _____ / _____ / _____
 Prescriber Full Name: _____ Prescriber License #: (ME,OS,RN) _____
 Prescriber Telephone #: _____ Prescriber Fax #: _____
 Drug Strength: _____

Please check below the diagnosis or indication for this product:

- Severe neutropenia in AIDS patients on antiretroviral therapy
- Severe Chronic Neutropenia: congenital cyclic idiopathic
- Cancer patients with HIV/AIDS receiving myelosuppressive chemotherapy

Select one of the following:

New Therapy **OR** Continuation of Therapy

Lab Test Date: _____ Absolute Neutrophil Count: _____ cells/mm3

What is the date range of therapy? Begin Date: _____ End Date: _____

Indicate dosage and frequency of dosing: _____

Prescriber's Signature: _____

Please attach a copy of the original prescription and lab results dated within the last two (2) months.

Fax information to:

<u>Ryan White Program-funded Pharmacy</u>	<u>Phone Number</u>	<u>Fax Number</u>
AIDS Healthcare Foundation (NW 170 th St.)	(305) 758-1984	(305) 758-8714
AIDS Healthcare Foundation (Biscayne Blvd.)	(305) 764-3780	(305) 764-3784
Citrus Health Network	(305) 825-0300, Ext. 2770	(305) 556-2580
Community Health of South Florida (Doris Ison)	(305) 253-5100	(305) 254-7795
Community Health of South Florida (MLKJCC)	(305) 248-4334	(305) 246-1016
Miami Beach Community Health Ctr (Alton Rd.)	(305) 538-8835, Ext. 1128	(305) 795-2156
Miami Beach Community Health Ct. (Bev. Press)	(305) 538-8835, Ext. 2242, 265, and 266	(305) 867-4312
PHT/South Florida AIDS Network	(305) 585-5890	(305) 585-0088

FOR RYAN WHITE PROGRAM USE ONLY			
Date: _____	Notified: _____		
Approved: _____	Start Date: _____	Expiration Date: _____	
Denied: _____	Reason: _____		

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Rev. 3/1/11

RYAN WHITE PROGRAM
Prior Authorization Form for Procrit® or Epogen® (both Epoetin Alpha)

Recipient's Full Name: _____ Date of Birth: _____ / _____ / _____
 Prescriber Full Name: _____ Prescriber License #: (ME,OS,RN) _____
 Prescriber Telephone #: _____ Prescriber Fax #: _____
 Drug Strength: _____

Please check below the diagnosis or indication for this product:

- Anemia associated with HIV
- Anemia associated with renal failure if patient is not on dialysis
- Anemia associated with chemotherapy
- Other _____

Select one of the following:

New Therapy **OR** Continuation of Therapy

Does the patient have active gastrointestinal bleeding? YES **OR** NO

Lab Test Date: _____ Hematocrit: _____ % Hemoglobin: _____ g/dl

Indicate dosage and frequency of dosing: _____

Prescriber's Signature: _____

Please attach a copy of the original prescription and lab results dated within the last two (2) months.

Fax information to:

<u>Ryan White Program-funded Pharmacy</u>	<u>Phone Number</u>	<u>Fax Number</u>
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FOR RYAN WHITE PROGRAM USE ONLY			
Date: _____	Notified: _____		
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