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MAGELLAN COMPLETE CARE

Prior Authorization

HIV Diagnosis Verification

Maximum Length of Approval = Six Months

This form is not the appropriate form for Fuzeon, Selzentry, or Serostim submissions.

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID #

Date of Birth (MM/DD/YYYY) ___ / ___ / ____

Recipient's Full Name

Prescriber's Full Name

Prescriber License # (ME, OS, ARNP, PA)

Prescriber Phone Number ___ - ____

Prescriber Fax Number ___ - ____

HIV Diagnosis Verification

Diagnosis / Indication for therapy:

- ☐ Maternal-fetal prophylaxis
- ☐ Sexual Assault (non-occupational exposure prophylaxis)
- ☐ HIV (Specify ICD-9 Code): _____
- ☐ Pre-Exposure HIV Prophylaxis **(complete entire form)**
- ☐ Other: _____ ***(complete entire form)***

Patients and providers that call 800-327-8613 to verbally attest to an HIV diagnosis will be allowed a one month override to allow time for diagnoses codes to be updated in the billing process or for this verification form to be submitted with medical records to Medicaid. Technology solutions have been implemented to allow claims to automatically process for maternal-fetal prophylaxis and assault victims

Pre-Exposure Prophylaxis (PrEP) for HIV

A detailed plan for preventive or risk reduction services (i.e., evaluation, counseling, and condom distribution) must be attached (in the form of progress notes or medical records) to this submission as per the CDC Guidance or Public Health Service Guidelines for HIV PrEP.

1. Creatinine Clearance **(official test results must be submitted)**: _____ mL/min

2. HIV antibody test **(official test results dated within past 90 days must be submitted)**: ○ Positive ○ Negative

3. Is patient at high risk for acquiring HIV infection? ○ Yes ○ No

4. Date of last sexually transmitted infections (STI) test: _____ ○ Positive ○ Negative

5. If so, what is the current treatment **(supporting documentation must be submitted)**? _____

6. Date of next office visit: _____

7. If this is continuation of therapy, has patient been compliant with PrEP medication? ○ Yes ○ No

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

REQUIRED FOR REVIEW: Copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs. **The provider must retain copies of all documentation for five years.**

Magellan Complete Care

MCC Physician Review: ○ I do not recommend Approval. ○ I recommend Approval for _____ months.

MCC Physician Signature: _____ **Date:** _____

Fax or mail completed forms to:

Magellan Complete Care
c/o Magellan Pharmacy Solutions
11013 West Broad Street, Suite 500
Glen Allen, VA 23060

Phone: 1-800-327-8613
TTY: 1-800-424-1694
Fax: 1-800-424-7982

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