OPTIMA HEALTH COMMUNITY CARE

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-319-5003. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

Drug Requested: **Biktarvy®** (bictegravir, emtricitabine, and tenofovir alafenamide)

DRUG INFORMATION: ***Complete all information below or authorization process will be delayed.***

Drug Form/Strength: ____________________

Dosing Schedule: ____________________ **Length of Therapy**: ____________________

Diagnosis: ____________________ ***ICD Code, if applicable***: ____________________

Quantity Limit **= 30 tablets/30 days**

DIAGNOSIS AND MEDICAL INFORMATION: ***To receive a ONE Year approval for Biktarvy®, all of the following questions MUST be answered to qualify or authorization process will be delayed.***

1. Does member have a diagnosis of HIV? ❑ Yes ❑ No

   AND
2. Is member 18 years or older? ❑ Yes ❑ No

   AND
3. Member will be tested for Hepatitis-B infection prior to initiation of therapy. ❑ Yes ❑ No

   AND
4. Does member have a creatinine clearance (CrCl) ≥ 30 mL/min within the last 30 days? ❑ Yes ❑ No

   AND
5. Member does **NOT** have moderate to severe hepatic impairment. ❑ Yes ❑ No

   AND
6. Member is **NOT** on other antiretroviral treatment (ART) medications. ❑ Yes ❑ No

   AND
7. Member is **NOT** on concurrent dofetilide or rifampin. ❑ Yes ❑ No

Medication being provided by a Specialty Pharmacy - **PropriumRx**

Patient Name: ____________________

Member Optima #: ____________________ Date of Birth: ____________________

Prescriber Name: ____________________

Prescriber Signature: ____________________ Date: ____________________

Office Contact Name: ____________________

Phone Number: ____________________ Fax Number: ____________________

DEA OR NPI #: ____________________

***Approved by Pharmacy and Therapeutics Committee:**
REVISED/UPDATED: 6/18/2018