Trogarzo (ibalizumab-uiyk) Prior Authorization Form
Florida AIDS Drug Assistance Program

Instructions:

- Fax completed form and documentation to ADAP confidential fax line at 850-412-2680.
- For any questions regarding this form, please contact Dr. Andréa Sciberras, Medical Director, Division of Disease Control and Health Protection and Dr. Joanne Urban, ADAP Clinical Pharmacist at HIVMedicalTeam@flhealth.gov.

Note: Prescriber will receive a written response via fax within three business days. If approved, the prescriber will complete the Trogarzo Enrollment Form and submit it to Thera Technologies, which will coordinate the drug distribution. The prescriber should coordinate the payment for any infusion-related costs and supplies with their local Ryan White Part A and/or B program, as needed.

PATIENT LAST NAME:	**PATIENT FIRST NAME:**	**DATE OF BIRTH:** / /
PRESCRIBER NAME (first and last):		
CREDENTIALS: ☐ **APRN**	☐ **DO** ☐ **MD**	☐ **PA**
PRESCRIBER PHONE:	**PRESCRIBER FAX:**	
PRESCRIBER EMAIL:		
OFFICE CONTACT NAME /NUMBER:		

COVERAGE FOR INSURED CLIENTS ***Select <u>one</u> of the options below.***	

☐	Patient's insurance will be the primary payor and ADAP will cover copay only
	• Is patient currently receiving Trogarzo? ☐ Y N ☐
	  ○ If yes, start date:
	  ○ If no, submit documentation of insurance approval for Trogarzo
	• Name of pharmacy that supplies or will supply Trogarzo:
	• Copay amount (if known): _____
	• **Submit form as instructed above. *If additional information is needed, you will be contacted to provide information before a coverage determination is made.***

☐	Patient's insurance has denied coverage and ADAP will be the sole payor • Submit documentation of insurance denial for Trogarzo • **Complete page 2 of this form and submit completed form and documentation as instructed above.**

TROGARZO CRITERIA FOR USE	
• **Due to the high cost, a maximum of 10 clients can be approved for Trogarzo full assistance through Florida ADAP at any given time.** • **All the criteria below must be met for the patient to be eligible to receive Trogarzo through Florida ADAP. If the patient does not meet one or more of these criteria, please submit a written explanation for the rationale for requesting Trogarzo for your patient.** **Select all that apply:**	
☐	Adult (≥ 18 years old) with HIV-1 infection
☐	Adherent to current antiretrovirals for ≥ 6 months **(Submit clinic note)**
☐	Most recent viral load > 200 copies/mL **(Submit results)**
☐	≤ 2 fully active ARVs from different classes available due to resistance, intolerance, or safety concerns **(Submit all current and prior resistance test results and documentation of allergies, intolerances, or safety issues)**
☐	≥ 1 fully active agent available to use with Trogarzo **- List other antiretrovirals that will be used with Trogarzo:**

☐ **I agree to submit HIV viral load and/or CD4 counts when requested.**

☐ **I understand that ADAP may rescind the approval for Trogarzo (with prior provider notice) for any reason (e.g., patient is not responding adequately (e.g., rising viral load while on therapy), patient is not adherent, fiscal constraints)**

PRESCRIBER SIGNATURE:	**Date:** / /

ADAP USE ONLY			
CLIENT ID NUMBER:		**Date Request Received:**	/ /
Request Approved:	☐ Yes ☐ No	**Reviewed by:**	