PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

SYMTUZA

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State, Zip:	City, State, Zip:	
Member Phone:		

Drug Name:	Expedited/Urgent
Directions:	
Patient belongs to (please check one): HEALTH PARTNERS	KIDZPARTNERS

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:

Q1. Is the patient currently receiving Symtuza therapy?

Yes No

Q2. Has the patient had no prior antiretroviral treatment, or is the patient virologically suppressed (HIV-1 RNA less than 50 copies per mL) on a stable antiretroviral regimen for at least 6 months?

Yes No

Q3. Does the patient have a history of therapeutic failure, a contraindication to or intolerance of the preferred HIV agents (such as Biktarvy or Triumeq (only for patients who are HLA-B5701 negative))?

Yes No

Q4. Is the patient switching between classes due to adverse effects or documented compliance issues due to pill burden or dosing frequency (must attach documentation).

Yes No

Q5. Requested Duration:

12 Months

Q6. Additional Information:

Physician Signature **Date**

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