Instructions:

- Fax completed form and documentation to ADAP confidential fax line at 850-412-2680.
- For any questions regarding this form, please contact Dr. Jeff Beal at 850-519-3734 or Jeff.Beal@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: / /

TROGARZO CRITERIA FOR USE

- **Due to the high cost, a maximum of 10 clients can be approved for Trogarzo 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:**

COVERAGE FOR INSURED CLIENTS
Select <u>one</u> of the options below. Submit documentation of insurance approval or denial for Trogarzo.

☐	Patient's insurance will be the primary payor and ADAP will cover copay only
☐	Patient's insurance has denied coverage and ADAP will be the sole payor

PRESCRIBER NAME (first and last):				
DISCIPLINE:	☐ **ARNP**	☐ **DO**	☐ **MD**	☐ **PA**
PRESCRIBER PHONE:		**PRESCRIBER FAX:**		
PRESCRIBER EMAIL:				
OFFICE CONTACT NAME /NUMBER :				

☐ **I agree to submit HIV viral load results at least every 2–4 months and CD4 counts when performed while patient is receiving Trogarzo. (Fax results to ADAP at 850-412-2680.)**

☐ **I agree to notify Florida ADAP immediately upon discontinuation of Trogarzo or if patient is not adherent to therapy. (Use the contact information for Dr. Beal on the first page of this form.)**

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

PRESCRIBER SIGNATURE:	**Date: / /**

ADAP USE ONLY

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