Trogarzo™ Prior Authorization Form
Florida AIDS Drug Assistance Program

Instructions:

- *Fax completed form and attachments (if applicable) to ADAP at (850) 412-2680.*
- *For any questions regarding this form, please contact Dr. Jeff Beal at (850) 519-3734.*

Note: *Prescriber will receive a written response via fax within 48 business hours. If approved, the prescriber will complete the Trogarzo™ Enrollment Form and submit to Thera Technologies who 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:

- ***All of the criteria below must be met for the patient to be eligible to receive Trogarzo™ through Florida ADAP. (Select all that apply)***
- ***If the patient does not meet one or more of these criteria, please attach written explanation for the rationale for requesting the use of Trogarzo™ in your patient.***
- ***Due to the high cost, a limit of 10 clients can be approved for Trogarzo™ assistance through Florida ADAP at any given time.***

○	Adult (≥ 18 years old) with HIV-1 infection
○	Adherent to current antiretrovirals for ≥ 6 months
○	Most recent viral load > 200 copies/mL
○	Documented viral resistance to ≥ 1 antiretroviral from ≥ 3 classes
○	Unable to design a regimen with ≥ 2 fully active agents from ≥ 2 classes (without Trogarzo™)
○	At least 1 fully active agent available to use with Trogarzo™
○	There is no clinical trial that is appropriate and accessible for my patient (clinicaltrials.gov)

COVERAGE FOR INSURED CLIENTS *(Select one of the options below)*

○	Patient's insurance will be the primary payor and ADAP will cover copay only ***OR***
○	Patient's insurance has denied coverage and ADAP will be the sole payor for Trogarzo™ (Attach copy of denial of coverage)

PRESCRIBER LAST NAME:	**PRESCRIBER FIRST NAME:**

DISCIPLINE:	○ **ARNP**	○ **DO**	○ **MD**	○ **PA**

PRESCRIBER PHONE:	**PRESCRIBER FAX:**

- ***I understand that Florida ADAP reserves the right to request supporting documentation (e.g., resistance and other laboratory test results) prior to approval or at any time during therapy.***
- ***I agree to submit HIV viral load and CD4 count results at least every 4 months while patient is receiving Trogarzo™.***
- ***I agree to notify Florida ADAP immediately upon discontinuation of Trogarzo™ or if patient is not adherent to therapy.***

PRESCRIBER SIGNATURE:		**Date:**	**/ /**

ADAP USE ONLY

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