

## **HUMAN IMMUNODEFICIENCY VIRUS SPECIALTY CARE PROGRAM**

Phone: **844-422-6400** • Fax: **888-850-4018** 



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3 STATEMEN	NT OF MEDIC	AL NECES	SITY: (Please A	ttach All I	Medical	Docume	ntation)			
			Date of Diagr					lo 🛚 Yes		
Diagnosis Procedur					Blood Re					
est/Procedure:	Date Performed:	Results:			Date Drav	vn	Hgb/Hc	t:	WBC:	
. OD/4/1-Cell					If Prior	Authorizati	on is Denied	:		
Viral Load					☐ Auton	natically Dra	aft Appeal for	Review		
. Liver Biopsy					☐ Send	Preferred F	ormulary Alte	rnatives		
INJECTION	TRAINING:	O To Be Administe	ered by Pharmacist O Ph	narmacist to Pro	vide Trainino	g O Patien	t Trained in MD (	Office O M	lanufacturer N	urse Support
INSURANC	E INFORMAT	TION: Please	to Patient's Home						cy to Cool	rdinate
INSURANC RESCRIPTION	E INFORMAT	TION: Please			pies of I	Pharmacy  tient's Da	and Medi	cal Card		
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INSURANCE RESCRIPTION Atient Name:  NRTIs/NNRTIS DESCOVY® 200/25r DEDURANT® 25mg DEMTRIVA® DEPIVIR® Protease Inhibito DAPTIVUS® 250mg DCRIXIVAN® DEVOTAZ™ 300/150r	Me  mg   INTELENT RESCRI RETROV SUSTIVA DISS KALETR MG   LEXIVA®	rion: Please rion: dication  CE® PTOR® rige A® 200/50mg	UIDEX® VIRAMUNE® VIRAMUNE XR® VIREAD®	d Back Co	Pate Pate Pate Pate Pate Pate Pate Pate	Pharmacy tient's Da <b>Dosage</b>	te of Birth:	/Direction	ns QT	
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