CLEAR
HEALTH ALLIANCE

Prior Authorization

HIV/HEP-B DIAGNOSIS VERIFICATION

THIS FORM IS NOT THE APPROPRIATE FORM FOR FUZEON, SELZENTRY, OR SEROSTIM SUBMISSIONS

Beneficiary's Medicaid ID#

Date of Birth (MM/DD/YYYY) / /

Beneficiary's Full Name

Prescriber's Full Name

Prescriber License # (ME, OS, RN)

Prescriber Phone Number -

Prescriber Fax Number -

HIV / HEP-B Diagnosis Verification

Diagnosis / Indication for therapy:

- ☐ **Maternal-fetal prophylaxis**
- ☐ **Sexual Assault (non-occupational exposure prophylaxis)**
- ☐ HIV **(Specify ICD-9 Code):** _____
- ☐ Hepatitis B **(Specify ICD-9 Code):** _____
- ☐ Pre-Exposure HIV Prophylaxis **(complete entire form)**
- ☐ Other: _____ **(complete entire form)**

Pre-Exposure Prophylaxis (PrEP) for HIV

A detailed plan for preventive or risk reduction services (i.e. evaluation, counseling, condom distribution) must be attached (in the form of progress notes or medical records) to this submission as per the CDC Guidance or Public Health Service Guidelines for HIV PrEP.

1) Creatinine Clearance **(official test results must be submitted):** _____ (mL/min)
2) HIV antibody test **(official test results dated within past 90 days must be submitted):** ☐ Positive ☐ Negative
3) Is patient at high risk for acquiring HIV infection? ☐ Yes ☐ No
4) Date of last sexually transmitted infections (STI) test? _____ ☐ Positive ☐ Negative
5) If so, what is the current treatment **(supporting documentation must be submitted)?** _____
6) Date of next office visit: _____
7) If this is continuation of therapy, has patient been compliant with PrEP medication? ☐ Yes ☐ No

Prescriber's Signature _____ DATE: _____

Please attach a copy of the original prescription.
The provider must retain copies of all documentation for five years.

Fax Information to:
Clear Health Alliance
Tel: (877) 577-9044
Fax: (877) 577-9045

For CLEAR HEALTH
PHARMACY Use Only

DATE: _____ NOTIFIED: _____
APPROVED: _____ START DATE: _____ EXPIRATION DATE: _____
DENIAL OVERRIDE: _____ REASON: _____