



Prior Authorization  
**Selzentry™ Maraviroc**

Beneficiary's Medicaid ID#	Date of Birth (MM/DD/YYYY)
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Beneficiary's Full Name	
<input type="text"/>	
Prescriber's Full Name	
<input type="text"/>	
Prescriber License # (ME, OS, RN)	
<input type="text"/>	
Prescriber Phone Number	Prescriber Fax Number
<input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/>
Pharmacy Name	
<input type="text"/>	
Pharmacy Medicaid Provider #	
<input type="text"/>	
Pharmacy Phone Number	Pharmacy Fax Number
<input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/>

1. Selzentry™ Dose Requested:

150mg twice daily     300mg twice daily     600mg twice daily

2. Has tropism testing been performed?     Yes\*     No  
\*If yes, a copy of the assay **MUST** be attached.

3. Is this patient > or = to 16 years of age?     Yes     No

4. Patient is:     Treatment-experienced    OR     Treatment-naïve?

5. Current (less than 6 months) lab results listed below must be attached:

CD4 count     Viral load     Resistance testing (in treatment experienced patient)

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

<b>For CLEAR HEALTH PHARMACY Use Only</b>			
DATE:	_____	NOTIFIED:	_____
APPROVED:	_____ START DATE:	_____ EXPIRATION DATE:	_____
DENIAL OVERRIDE:	_____ REASON:	_____	_____