



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.

Mail or Fax Information to:

Simply Healthcare Plans
Health Services Department
1701 Ponce de Leon Blvd., Suite 300
Miami, FL 33134
Phone: (877) 577-9044
Fax: (877) 577-9045

For SHP Use Only
DATE: NOTIFIED:
APPROVED: START DATE: EXPIRATION DATE:
DENIAL OVERRIDE: REASON: