CLEAR
HEALTH ALLIANCE

Prior Authorization

Selzentry™ Maraviroc

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

Pharmacy Name

Pharmacy Medicaid Provider #

Pharmacy Phone Number

Pharmacy Fax Number

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-naive?
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

For CLEAR HEALTH PHARMACY Use Only

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