TEXAS HIV MEDICATION PROGRAM
MEDICAL CERTIFICATION FORM

(TO BE COMPLETED BY PHYSICIAN) **Texas HIV Medication Code (if known)** _____

The information requested is necessary to determine the patient's eligibility for program-supplied, HIV-related therapy as prescribed by you. All information requested will be kept strictly confidential by the Texas Department of State Health Services; personal identifying info is never released.

*** Both pages are required. ***

PATIENT INFORMATION

Full Name: _____

Mailing Address: _____ Apt. # _____

City, State, Zip: _____ Phone #: (____) _____

Date of Birth: ____ / ____ / ____ Social Security Number: _____
Month Day Year

Requested Pharmacy: _____

I hereby certify that this patient has been diagnosed with HIV infection, and I am reporting the following viral load and CD4 count:

Plasma RNA Viral Load:	**Test Date:**		**Current CD4 Count:**	**Test Date:**
_____**copies/ml**	/ /			/ /

In the sections below, mark the appropriate box to specify supply quantity for each medication prescribed. Black-filled boxes indicate the medication is not eligible for a 90-day supply. Some medication strengths or formulations are excluded from 90-day availability based on minimal demand. Please refer to the THMP Medication Formulary and Maximum Quantities Table for more details.

I certify that this patient is being prescribed the following medications (eligibility criteria for each drug is detailed in the THMP Program Guidelines):

Quantity Prescribed (days)				**Quantity Prescribed** (days)				**Quantity Prescribed** (days)		
90	**30**			**90**	**30**			**90**	**30**	
■	☐	**Dapsone**	**OR**	■	☐	**pentamidine**	**OR**	☐	☐	**SMZ/TMP** *(choose one)*
■	☐	**acyclovir**	**OR**	☐	☐	**famciclovir**	**OR**	☐	☐	**Valacyclovir** *(choose one)*
■	☐	**Gynazole** (butoconazole)	**OR**	■	☐	**Monistat** (tioconazole)	**OR**	■	☐	**terconazole** topical creams
■	☐	**azithromycin**	**OR**	☐	☐	**Clarithromycin** *(choose one)*				
■	☐	**atovaquone** (Mepron)						☐	☐	**clindamycin**
■	☐	**ethambutol**						■	☐	**clotrimazole troche** lozenges
☐	☐	**fluconazole**						■	☐	**isoniazid**
☐	☐	**itraconazole**						■	☐	**nystatin** oral suspension
■	☐	**leucovorin** calcium tablets *(provide RX dosage details)*						■	☐	**Oravig** (miconazole buccal tablets)
■	☐	**megesterol acetate** oral suspension						■	☐	**prednisone**
■	☐	**pyrimethamine** (Daraprim)						■	☐	**primaquine phosphate**
■	☐	**rifabutin**						■	☐	**rifampin**
☐	☐	**valganciclovir** (Valcyte)						☐	☐	**sulfadiazine**
■	☐	**Egrifta** (tesamorelin acetate P/F)						■	☐	**voriconazole**
☐	☐	**Mytesi** (crofelemer)								

*** Continue to next page. Both pages are required. ***

Patient Name: _____
Date of Birth: _____ Texas HIV Medication Code (if known):_____

*** Continued from previous page. Both pages are required. ***

PRESCRIBED ANTIRETROVIRALS: MONTHLY CLIENT LIMIT OF FOUR ANTIRETROVIRALS (ARVs)

Quantity Prescribed (days) 90	30		Quantity Prescribed (days) 90	30	
■	☐	**abacavir** (Ziagen)*	☐	☐	**invirase** (Saquinavir)
☐	☐	**atazanavir** (Reyataz)	☐	☐	**Isentress** (raltegravir)
☐	☐	**Atripla** (Sustiva/Truvada)*****	☐	☐	**Isentress HD** (raltegravir)
☐	☐	**Biktarvy** (bictegravir/emtricitabine/tenofovir)	☐	☐	**Juluca** (dolutegravir/rilpivirine)*
☐	☐	**cobicistat** (Tybost)	☐	☐	**lamivudine** (3TC)
☐	☐	**Combivir** (AZT/3TC)*****	☐	☐	**lopinavir/ritonavir** (Kaletra)
☐	☐	**Complera** (Edurant/Truvada)*****	☐	☐	**maraviroc** (Selzentry) – CCR5 monotropism proof via assay **must** be attached.
☐	☐	**darunavir** (Prezista)	☐	☐	**nelfinavir** (Viracept)
■	☐	**delavirdine** (Rescriptor)	☐	☐	**nevirapine** (Viramune XR)
☐	☐	**Descovy** (Emtriva/Viread TAF)*****	☐	☐	**Odefsey** (Edurant/Emtriva/Viread TAF)*
☐	☐	**didanosine** (DDI EC)	☐	☐	**Prezcobix** (Prezista/Tybost)*
☐	☐	**dolutegravir** (Tivicay)	☐	☐	**rilpivirine** (Edurant)
☐	☐	**efavirenz** (Sustiva)	☐✦	☐	**ritonavir** (Norvir) ✦*90-day supply may not exceed 360 tablets*
☐	☐	**elvitegravir** (Vitekta)	☐	☐	**stavudine** (D4T)
☐	☐	**emtrictabine** (Emtriva)	☐	☐	**Stribild** (Vitekta/Tybost/Emtriva/Viread TDF)*
☐	☐	**enfuvirtide** (Fuzeon)	■	☐	**Symtuza** (darunavir/cobicistat/emtricitabine/tenofovir)*
☐	☐	**Epzicom** (abacavir/3TC)*****	☐	☐	**tenofovir** (Viread TDF)
☐	☐	**etravirine** (Intelence) –For treatment experienced w/viral resistance/toxicity to ARV agents	■	☐	**tipranavir** (Aptivus)
☐	☐	**Evotaz** (Reyataz/Tybost)*	☐	☐	**Triumeq** (Tivicay/abacavir/3TC)*
☐	☐	**fosamprenavir** (Lexiva)-if unboosted dosage, written justification from physician required	☐	☐	**Trizivir** (AZT/abacavir/3TC)*****
☐	☐	**Genvoya** (Vitekta/Tybost/Emtriva/Viread TAF)*	☐	☐	**Truvada** (Emtriva/Viread TDF)*****
☐	☐	**indinavir** (Crixivan)	☐	☐	**zidovudine** (AZT)

Note:** Combivir, Descovy, Evotaz, Epzicom, Prezcobix, Truvada & Juluca each count as 2 ARVs; Atripla, Complera, Odefsey, Trizivir, Triumeq & Biktarvy each count as 3 ARVs; Stribild, Symtuza, and Genvoya each count as 4 ARVs. ***HLA-B*5701 test result of negative is required for treatment-naïve patients starting medications that contain abacavir (Ziagen, Epzicom, Trizivir or Triumeq).

PHYSICIAN SIGNATURE**:**_____ TX MD/DO LICENSE #: _____

PRINTED NAME OF PHYSICIAN:_____

OFFICE ADDRESS:_____

TELEPHONE:_____ FAX:_____ DATE:____/____/____

*****NOTICE*** Changes in therapy after initial approval and/or recertification may be faxed to (512) 533-3178.**

If this form is completed as part of an initial program application or recertification, it should be submitted together with all requested documentation by fax (512-533-3178) or mailed to:

Texas HIV Medication Program, ATTN: MSJA - MC1873, PO Box 149347, Austin, TX 78714-9347