TEXAS HIV MEDICATION PROGRAM
MEDICAL CERTIFICATION FORM
Fax to (512) 989-4003

(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 (mm/dd/yyyy): _____ Social Security Number: _____

Requested Pharmacy: _____

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

Plasma RNA Viral Load: copies/ml	**Test Date** (mm/dd/yyyy)**:**	**Current CD4 Count:**	**Test Date** (mm/dd/yyyy)**:**

***REQUIRED* Is this patient new to any medications in this antiretroviral therapy regimen?**
(check one) **Yes** ☐ **No** ☐

On the following page, mark the appropriate box to specify supply quantity for each medication prescribed. Please refer to the THMP Medication Formulary and Maximum Quantities Table for available dosages and quantities of medications.

Note:** Combivir, Descovy, Dovato, Evotaz, Epzicom, Prezcobix, Truvada, and Juluca each count as 2 ARVs; Atripla, Complera, Odefsey, Trizivir, Triumeq, Biktarvy, and Delstrigo 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).

I certify that this patient is being prescribed the medications selected on the attached page.

Physician Signature**:** _____ TX MD/DO License # _____

Printed Name of Physician: _____

Office Address: _____

Phone: _____ Fax: _____ Date: _____

*****NOTICE*** Changes in therapy after initial approval and/or recertification may be faxed to (512) 989-4003.**

If this form is completed as part of an initial program application, it should be mailed to:
Texas HIV Medication Program, ATTN: MSJA - MC1873, PO Box 149347, Austin, TX 78714-9347

Patient Name: _____

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

Qty Prescribed (days)			**Qty Prescribed** (days)			**Qty Prescribed** (days)	
30 day			**30 day**			**30 day**	
☐	**azithromycin**	**OR**	☐	**Clarithromycin**			*(choose one)*
☐	**Dapsone**	**OR**	☐	**pentamidine**	**OR**	☐	**SMZ/TMP** *(choose one)*
☐	**acyclovir**	**OR**	☐	**famciclovir**	**OR**	☐	**Valacyclovir** *(choose one)*
☐	**Gynazole** (butoconazole)	**OR**	☐	**Monistat** (tioconazole)	**OR**	☐	**terconazole** topical *(choose one)*
☐	**fluconazole**	**OR**	☐	**itraconazole**	**OR**	☐	**Voriconazole** *(choose one)*
☐	**atovaquone** (Mepron)					☐	**clindamycin**
☐	**clotrimazole troche**					☐	**Daraprim** (pyrimethamine)
☐	**ethambutol**					☐	**isoniazid**
☐	**leucovorin** calcium tablets					☐	**megesterol acetate** oral susp
☐	**nystatin** oral susp					☐	**Oravig** (miconazole)
☐	**prednisone**					☐	**primaquine phosphate**
☐	**rifampin**					☐	**rifabutin**
☐	**sulfadiazine**					☐	**Valcyte** (valganciclovir)

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

30 day		**30 day**		**30 day**	
☐	**Aptivus** (TPV)	☐	**Atripla** (ABC/FTC/TDF)	☐	**Biktarvy** (BIC/FTC/TAF)
☐	**Combivir** (AZT/3TC)	☐	**Complera** (FTC/RPV/TDF)	☐	**Delstrigo** (DOR/3TC/TDF)
☐	**Descovy** (FTC/TAF)	☐	**Dovato** (DTG/3TC)	☐	**Edurant** (RPV)
☐	**Emtriva** (FTC)	☐	**Epivir** (3TC)	☐	**Epzicom** (ABC/3TC)
☐	**Evotaz** (ATV/c)	☐	**Genvoya** (c/EVG/FTC/TAF)	☐	**Intelence** (ETR)
☐	**Invirase** (SQV)	☐	**Isentress** (RAL)	☐	**Isentress HD** (RAL)
☐	**Juluca** (DTG/RPV)	☐	**Kaletra** (LPV/r)	☐	**Lamivudine/Tenofovir** (3TC/TDF)
☐	**Lexiva** (FPV)	☐	**Norvir** (ritonavir)	☐	**Odefsey** (RPV/FTC/TAF)
☐	**Pifeltro** (DOR)	☐	**Prezcobix** (DRV/c)	☐	**Prezista** (DRV)
☐	**Reyataz** (ATV)	☐	**Rukobia ER** (fostemsavir)	☐	**Selzentry** (MVC)
☐	**Stribild** (c/EVG/FTC/TDF)	☐	**Sustiva** (EFV)	☐	**Symfi** (EFV/3TC/TDF)
☐	**Symtuza** (c/DRV/FTC/TAF)	☐	**Tivicay** (DTG)	☐	**Triumeq** (DTG/ABC3TC)
☐	**Trizivir** (AZT/ABC/3TC)	☐	**Truvada** (FTC/TDF)	☐	**Viracept** (NFV)
☐	**Viramune XR** (NVP)	☐	**Viread** (TDF)	☐	**Ziagen** (ABC)
☐	**Zidovudine** (AZT)				

ATTENTION: The medications below will be suspended November 1, 2021. Please ensure there is a transition plan to another program before adding these medications through THMP.

☐	**Amlodipine** (5mg/#90)	☐	**Atorvastatin** (20mg/#90)	☐	**Baraclude**
☐	**Duloxetine** (30mg/#90)	☐	**Egrifta** (tesamorelin acetate P/F)	☐	**Gabapentin** (300mg/#100)
☐	**Hydrocholorothiazide** (25mg/#100)	☐	**Lisinopril** (10mg/#100)	☐	**Livalo** (2mg/#90)
☐	**Metformin** (500mg/#100)	☐	**Metoprolol Tart** (50mg/#100)	☐	**Mytesi** (crofelemer)
☐	**Sertraline (**50mg/#30)	☐	**Trazodone** (100mg/#100)	☐	**Vemlidy**
☐	**Zypitamag** (2mg/#90)				