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. Medications marked n/a indicate the medication is not eligible for a 90-day supply. Please refer to the [THMP Medication Formulary and Maximum Quantities Table](https://www.dshs.texas.gov/hivstd/meds/files/formulary.pdf) for available dosages and quantities of medications. Providers should reserve prescribing a 90-day medication supply for people on stable medication regimens; medications that are new or have changed in dose for a patient are not eligible to be dispensed as 90-day supply.

## \*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**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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** | **90 day** | | | **30** | | | **90 day** | | | | **30** | | **90 day** | | | |
| 🞏 | 🞏 | **Aptivus** (TPV) | | 🞏 | | 🞏 | | | **Atripla** (ABC/FTC/TDF) | | 🞏 | 🞏 | | | **Biktarvy** (BIC/FTC/TAF) |
| 🞏 | n/a | **Biktarvy pedi** (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 pedi** (RAL) | | 🞏 | | 🞏 | | | **Isentress HD** (RAL) | | 🞏 | 🞏 | | | **Juluca** (DTG/RPV) |
| 🞏 | 🞏 | **Kaletra** (LPV/r) | | 🞏 | | n/a | | | **Lamivudine/Tenofovir** (3TC/TDF) | | 🞏 | 🞏 | | | **Lexiva** (FPV) |
| 🞏 | 🞏 | **Norvir** (ritonavir) | | 🞏 | | 🞏 | | | **Odefsey** (RPV/FTC/TAF) | | 🞏 | n/a | | | **Pifeltro** (DOR) |
| 🞏 | 🞏 | **Prezcobix** (DRV/c) | | 🞏 | | 🞏 | | | **Prezista** (DRV) | | 🞏 | 🞏 | | | **Reyataz** (ATV) |
| 🞏 | n/a | **Rukobia ER**(fostemsavir) | | 🞏 | | 🞏 | | | **Selzentry** (MVC) | | 🞏 | 🞏 | | | **Stribild** (c/EVG/FTC/TDF) |
| 🞏 | 🞏 | **Sustiva** (EFV) | | 🞏 | | n/a | | | **Symfi** (EFV/3TC/TDF) | | 🞏 | n/a | | | **Symtuza** (c/DRV/FTC/TAF) |
| 🞏 | 🞏 | **Tivicay** (DTG) | | 🞏 | | n/a | | | **Tivicay pedi** (DTG) | | 🞏 | 🞏 | | | **Triumeq** (DTG/ABC3TC) |
| 🞏 | 🞏 | **Trizivir** (AZT/ABC/3TC) | | 🞏 | | 🞏 | | | **Truvada** (FTC/TDF) | | 🞏 | 🞏 | | | **Viracept** (NFV) |
| 🞏 | 🞏 | **Viramune XR** (NVP) | | 🞏 | | 🞏 | | | **Viread** (TDF) | | 🞏 | 🞏 | | | **Ziagen** (ABC) |
| 🞏 | 🞏 | **Zidovudine** (AZT) | |  | |  | | |  | |  |  | | |  |
| **90 day** | | | | **90 day** | | | | | | | **90 day** | | | | | |
| 🞏 | **Amlodipine** (5mg/#90) | | | 🞏 | | | | **Atorvastatin** (20mg/#90) | | | 🞏 | | **Duloxetine** (30mg/#90) | | | |
| 🞏 | **Gabapentin** (300mg/#100) | | | 🞏 | | | | **Hydrocholorothiazide** (25mg/#100) | | | 🞏 | | **Lisinopril** (10mg/#100) | | | |
| 🞏 | **Metformin** (500mg/#100) | | | 🞏 | | | | **Metoprolol Tart** (50mg/#100) | | | 🞏 | | **Sertraline (**50mg/#100) | | | |
| 🞏 | **Trazodone** (100mg/#100) | | |  | | | |  | | |  | |  | | | |