

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

SELZENTRY (maraviroc)

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO 855-828-4992**

CRITERIA:

- Minimum age: 16 years old.
- Documentation of a co-receptor tropism assay test indicating CCR5-tropic HIV-1 infection.
- Documentation of optimized background therapy for the treatment of HIV-1 infection.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Updated letter of medical necessity

9/20/10

<https://medicaid.utah.gov/pharmacy/>