FUTURE SCRIPTS Secure

Please complete ALL information below and fax your request to 1-888-671-5285

Egrifta® Coverage Determination Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type of Coverage Determination Requested:

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

Select the diagnosis below:

❑ HIV-associated lipodystrophy (excess abdominal fat reduction)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Select if the patient has the following conditions:

- ❑ Hypothalamic-pituitary axis due to hypophysectomy, hypopituitarism, pituitary tumor/surgery, or head irradiation or trauma
- ❑ Hypersensitivity to tesamorelin and/or mannitol
- ❑ Malignancy [active malignancies (either newly diagnosed or recurrent) should be inactive and completely treated prior to initiating therapy]
- ❑ Pregnancy

Please document the patient's waist-to-hip ratio: _____

Please document the patient's waist circumference: _____

Is the prescriber an HIV-infection specialist? ❑ **Yes** ❑ **No**

Is there documentation that patient is receiving antiretroviral therapy (ART)? ❑ **Yes** ❑ **No**

Is there documentation that revision of the patient's ART regimen and weight loss efforts (dietary modification and exercise) has been ineffective in reducing the excess visceral adipose tissue (VAT)? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.