

FLORIDA MEDICAID
Prior Authorization
HIV/HEP-B DIAGNOSIS VERIFICATION



THIS FORM IS NOT THE APPROPRIATE FORM FOR FUZEON, SELZENTRY, OR SEROSTIM SUBMISSIONS

Beneficiary's Medicaid ID#

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Date of Birth (MM/DD/YYYY)

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Beneficiary's Full Name

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Prescriber's Full Name

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Prescriber License # (ME, OS, RN)

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Prescriber Phone Number

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Prescriber Fax Number

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HIV / HEP-B Diagnosis Verification

- Diagnosis / Indication for therapy:
- Maternal-fetal prophylaxis
 - Sexual Assault (non-occupational exposure prophylaxis)
 - HIV (Specify ICD-9 Code): _____
 - Hepatitis B (Specify ICD-9 Code): _____
 - Pre-Exposure HIV Prophylaxis (complete entire form)
 - Other: _____ (complete entire form)

Patients and providers that call (800)603-1714 or (877)553-7481 to verbally attest to an HIV or Hepatitis B diagnosis will be allowed a one month override to allow time for diagnoses codes to be updated in the billing process or for this verification form to be submitted with medical records to Medicaid. Technology solutions have been implemented to allow claims to automatically process for maternal-fetal prophylaxis and assault victims.

Pre-Exposure Prophylaxis (PrEP) for HIV

A detailed plan for preventive or risk reduction services (i.e. evaluation, counseling, condom distribution) must be attached (in the form of progress notes or medical records) to this submission as per the CDC Guidance or Public Health Service Guidelines for HIV PrEP.

- 1) Creatinine Clearance (official test results must be submitted): _____ (mL/min)
- 2) HIV antibody test (official test results dated within past 90 days must be submitted): Positive Negative
- 3) Is patient at high risk for acquiring HIV infection? Yes No
- 4) Date of last sexually transmitted infections (STI) test? _____ Positive Negative
- 5) If so, what is the current treatment (supporting documentation must be submitted)? _____
- 6) Date of next office visit: _____
- 7) If this is continuation of therapy, has patient been compliant with PrEP medication? Yes No

Prescriber's Signature _____ DATE: _____

Please attach a copy of the original prescription.
The provider must retain copies of all documentation for five years.

Mail or Fax Information to:
Magellan Medicaid Administration, Inc.
Prior Authorization
P. O. Box 7082
Tallahassee, FL 32314-7082
Phone: (877) 553-7481
Fax: (877) 614-1078

For AHCA Use Only	
DATE: _____	NOTIFIED: _____
APPROVED: _____	START DATE: _____ EXPIRATION DATE: _____
DENIAL OVERRIDE: _____	REASON: _____