

Pharmacy Prior Authorization Form

Last Reviewed: Nov. 11

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Selzentry (maraviroc) Urgent Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

- Selzentry tablets 150 mg
- Selzentry tablets 300 mg

Dose: _____ Start date: _____

Priority Health Precertification Requirements:

Authorization for Selzentry requires:

- Diagnosis of CCR5-tropic HIV 1
- Submission of laboratory confirmation of diagnosis

Please Complete the Following Information:

Diagnosis:

- CCR5-tropic HIV 1
- Other: _____ Please provide rationale for use: _____

Lab results confirming the diagnosis of CCR5-tropic HIV 1 have been submitted along with this request:

- Yes
- No – Rationale for use: _____

New request or continuation of therapy:

- New
- Continuation of therapy

*** All fields must be complete and legible for Prior Authorization Review***

Please fax this request to: (877)974-4411 toll free or (616)942-8206
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX