COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

DUR MEDICATION DOVATO® (dolutegravir/lamivudine)

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name: | | | | | | | | | | | | |

First Name: | | | | | | | | | | | | |

Medicaid ID Number: | | | | | | | | | | | | |

Date of Birth: | | | – | | | – | | | | |

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: | | | | | | | | | | | | |

First Name: | | | | | | | | | | | | |

NPI Number: | | | | | | | | | | |

Phone Number: | | | – | | | | – | | | | |

Fax Number: | | | – | | | | – | | | | |

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

 Revision Date: 10/16/2020

Member's Last Name:

Member's First Name:

DIAGNOSIS AND MEDICAL INFORMATION

For initial approval, complete the following questions to receive a 1-year approval:

1. Is the member 18 years of age or older? **AND**
   ☐ Yes ☐ No

2. Does the member have a diagnosis of human immunodeficiency virus type 1 (HIV-1)? **AND**
   ☐ Yes ☐ No

3. Is there confirmation that the member is not taking any other antiretroviral (ARV) medications? **AND**
   ☐ Yes ☐ No

4. Is there confirmation that the member does not have an estimated creatinine clearance (CrCl) < 50 mL/min? **AND**
   ☐ Yes ☐ No

5. Is there confirmation that the member does not have severe hepatic impairment (Child-Pugh C)? **AND**
   ☐ Yes ☐ No

6. Is there confirmation that the member is not taking any medications contraindicated with Dovato (e.g., dofetilide)? **AND**
   ☐ Yes ☐ No

7. Is there confirmation that the member is not in the first trimester of pregnancy or attempting to conceive?
   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

For renewal, complete the following questions to receive a 1-year approval:

8. Does the member continue to meet the above criteria? **AND**
   ☐ Yes ☐ No

9. Does the member demonstrate documented efficacy (e.g., reduced viral load/improved CD4, remaining virologically suppressed)? **AND**
   ☐ Yes ☐ No

10. Does the member have absence of treatment-limiting adverse effects?
    ☐ Yes ☐ No

Prescriber Signature (Required)
By signature, the Physician confirms the above information is accurate and verifiable by member records.

Date

Please include ALL requested information; Incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:
Magellan Medicaid Administration / ATTN: MAP
11013 W. Broad Street, Glen Allen, VA 23060

Virginia Medicaid Pharmacy Services Portal: http://www.virginiamedicaidpharmacyservices.com

 Revision Date: 10/16/2020