TEXAS HIV MEDICATION PROGRAM (THMP)
TROGARZO MEDICAL CERTIFICATION FORM

FAX to (512) 989-4003

(TO BE COMPLETED BY PHYSICIAN) **Texas HIV Medication Code (if known)** _____

The information on this form is necessary to determine the patient's eligibility for program-supplied, HIV-related therapy as prescribed by you. All information on this form will be kept strictly confidential by the Department of State Health Services. Personal identifying information is never released.

PATIENT INFORMATION

Full Name: _____

Mailing Address: _____ Apt. # _____

City, State, Zip: _____ Phone # (____) _____

Date of Birth: _____/_____/_____ Social Security Number: _____
Month Day Year

*****This form is intended as a supplement to the standard THMP Medical Certification Form and should be submitted only if Trogarzo is being requested for your patient.*****

PRESCRIBED TROGARZO (Ibalizumab-uiyk):

☐ **New** ☐ **Continuing Therapy** ☐ **Restart Therapy**

Infusion treatment has been secured at the following facility: _____

This treatment will be funded by the following source: _____

Please designate the pharmacy Trogarzo will be sent to: _____

**** Clients requesting Trogarzo must be assigned to an approved Infusion Specialty Pharmacy as their Secondary Site. If the desired Infusion Specialty Pharmacy is not already part of the THMP Participating Pharmacy network, pharmacy will need to apply via this form: dshs.texas.gov/hivstd/meds/files/ParticipatingPharmacyRequest.pdf**

By signing this form, I certify that the following is true:

1. I have prescribed Trogarzo to the patient named above because it is the most medically appropriate treatment.
2. This patient will receive antiretroviral medications along with Trogarzo.
3. The patient has secured funding and an appropriate location for infusion services that are required to administer Trogarzo.
4. The patient has submitted the Trogarzo Enrollment form to Thera Technologies. A copy of this form is enclosed for the Texas HIV Medication Program.
5. I attest that this patient does not have any contraindications to the prescribed medication and/or is not taking a medication that is contraindicated with the prescribed medication.
6. I attest that this patient is competent and willing to be treated and adhere to treatment guidelines.
7. I attest that this patient is aware of potential side effects of this medication, including immune reconstitution syndrome.
8. I agree to maintain an appropriate treatment plan for this patient.
9. This patient is not currently receiving Trogarzo through a Pharmacy Assistance Program (PAP).

In order to assess the effectiveness of this medication, we must receive follow-up data and documentation on enrolled patients, including confirmation of infusion therapy provided with this medication. Please provide contact information for your office so we may follow up on treatment progress periodically. Please note that an inability to respond to program inquiries may result in the discontinuation of Trogarzo through this program.

Person in your office to contact: _____

Best day/time to call: _____

PHYSICIAN SIGNATURE: _____ TX MD/DO LICENSE #: _____

PRINTED NAME OF PHYSICIAN: _____

OFFICE ADDRESS: _____

TELEPHONE: _____ DATE ____/____/____