

**TEXAS HIV MEDICATION PROGRAM
MEDICAL CERTIFICATION FORM
Fax to (512) 989-4003**

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

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

*** Both pages are required. ***

PATIENT INFORMATION

Full Name: _____

Mailing Address: _____ Apt. # _____

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

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

Requested Pharmacy: _____

I hereby certify that this patient has been diagnosed with HIV, and I am reporting the following viral load and CD4 count:

Plasma RNA Viral Load: copies/ml	Test Date: / /	Current CD4 Count: 	Test Date: / /
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REQUIRED Is this patient new to any medications in this antiretroviral therapy regimen?
(check one) Yes No

On the following page, mark the appropriate box to specify supply quantity for each medication prescribed. Medications marked n/a indicate the medication is not eligible for a 90-day supply. **Please refer to the [THMP Medication Formulary and Maximum Quantities Table](#) for available dosages and quantities of medications.**

Providers should reserve prescribing a 90-day medication supply for people on stable medication regimens; medications that are new or have changed in dose for a patient are not eligible to be dispensed as 90-day supply.

***Note:** Combivir, Descovy, Dovato, Evotaz, Epzicom, Prezcoibix, Truvada, & Juluca each count as 2 ARVs; Atripla, Complera, Odefsey, Trizivir, Triumeq, Biktarvy, & Delstrigo each count as 3 ARVs; Stribild, Symtuza, and Genvoya each count as 4 ARVs. **HLA-B*5701 test result of negative is required for treatment-naïve patients starting medications that contain abacavir (Ziagen, Epzicom, Trizivir, or Triumeq).**

I certify that this patient is being prescribed the medications selected on the attached page.

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

PRINTED NAME OF PHYSICIAN: _____

OFFICE ADDRESS: _____

TELEPHONE: _____ FAX: _____ DATE: ____/____/____

*****NOTICE***** Changes in therapy after initial approval and/or recertification may be faxed to (512) 989-4003.

If this form is completed as part of an initial program application, it should be mailed to:
Texas HIV Medication Program, ATTN: MSJA - MC1873, PO Box 149347, Austin, TX 78714-9347

Patient Name: _____
 Date of Birth: _____ Texas HIV Medication Code (if known): _____

Qty Prescribed (days)		Qty Prescribed (days)		Qty Prescribed (days)							
90	30	90	30	90	30						
n/a	<input type="checkbox"/>	azithromycin	OR	<input type="checkbox"/>	<input type="checkbox"/>	Clarithromycin				<i>(choose one)</i>	
n/a	<input type="checkbox"/>	Dapsone	OR	n/a	<input type="checkbox"/>	pentamidine	OR	n/a	<input type="checkbox"/>	SMZ/TMP <i>(choose one)</i>	
n/a	<input type="checkbox"/>	acyclovir	OR	<input type="checkbox"/>	<input type="checkbox"/>	famciclovir	OR	<input type="checkbox"/>	<input type="checkbox"/>	Valacyclovir <i>(choose one)</i>	
n/a	<input type="checkbox"/>	Gynazole (butoconazole)	OR	n/a	<input type="checkbox"/>	Monistat (tioconazole)	OR	n/a	<input type="checkbox"/>	terconazole topical <i>(choose one)</i>	
<input type="checkbox"/>	<input type="checkbox"/>	fluconazole	OR	<input type="checkbox"/>	<input type="checkbox"/>	itraconazole	OR	<input type="checkbox"/>	<input type="checkbox"/>	Voriconazole <i>(choose one)</i>	
n/a	<input type="checkbox"/>	atovaquone (Mepron)				<input type="checkbox"/>	<input type="checkbox"/>	clindamycin			
n/a	<input type="checkbox"/>	ethambutol				n/a	<input type="checkbox"/>	clotrimazole troche			
n/a	<input type="checkbox"/>	leucovorin calcium tablets				n/a	<input type="checkbox"/>	isoniazid			
n/a	<input type="checkbox"/>	megesterol acetate oral susp				n/a	<input type="checkbox"/>	nystatin oral susp			
n/a	<input type="checkbox"/>	Daraprim (pyrimethamine)				n/a	<input type="checkbox"/>	Oravig (miconazole)			
n/a	<input type="checkbox"/>	rifabutin				n/a	<input type="checkbox"/>	prednisone			
<input type="checkbox"/>	<input type="checkbox"/>	Valcyte (valganciclovir)				n/a	<input type="checkbox"/>	primaquine phosphate			
n/a	<input type="checkbox"/>	Egrifta (tesamorelin acetate P/F)				n/a	<input type="checkbox"/>	rifampin			
<input type="checkbox"/>	<input type="checkbox"/>	Mytesi (crofelemer)				<input type="checkbox"/>	<input type="checkbox"/>	sulfadiazine			
n/a	<input type="checkbox"/>	Baraclude		n/a	<input type="checkbox"/>	Vemlidy					
<input type="checkbox"/>	n/a	Amlodipine		<input type="checkbox"/>	n/a	Atorvastatin		<input type="checkbox"/>	n/a	Duloxetine	
<input type="checkbox"/>	n/a	Gabapentin		<input type="checkbox"/>	n/a	Hydrochlorothiazide		<input type="checkbox"/>	n/a	Lisinopril	
<input type="checkbox"/>	n/a	Livalo		<input type="checkbox"/>	n/a	Metformin		<input type="checkbox"/>	n/a	Metoprolol Tart	
<input type="checkbox"/>	n/a	Sertraline		<input type="checkbox"/>	n/a	Trazodone		<input type="checkbox"/>	n/a	Zypitamag	
ANTIRETROVIRALS RX: MONTHLY CLIENT LIMIT OF FOUR ANTIRETROVIRALS (ARVs)											
n/a	<input type="checkbox"/>	Aptivus (TPV)		<input type="checkbox"/>	<input type="checkbox"/>	Atripla (ABC/FTC/TDF)		<input type="checkbox"/>	<input type="checkbox"/>	Biktarvy (BIC/FTC/TAF)	
<input type="checkbox"/>	<input type="checkbox"/>	Combivir (AZT/3TC)		<input type="checkbox"/>	<input type="checkbox"/>	Complera (FTC/RPV/TDF)		n/a	<input type="checkbox"/>	Delstrigo (DOR/3TC/TDF)	
<input type="checkbox"/>	<input type="checkbox"/>	Descovy (FTC/TAF)		<input type="checkbox"/>	<input type="checkbox"/>	Dovato (DTG/3TC)		<input type="checkbox"/>	<input type="checkbox"/>	Edurant (RPV)	
<input type="checkbox"/>	<input type="checkbox"/>	Emtriva (FTC)		<input type="checkbox"/>	<input type="checkbox"/>	Epivir (3TC)		<input type="checkbox"/>	<input type="checkbox"/>	Epzicom (ABC/3TC)	
<input type="checkbox"/>	<input type="checkbox"/>	Evotaz (ATV/c)		<input type="checkbox"/>	<input type="checkbox"/>	Genvoya (c/EVG/FTC/TAF)		<input type="checkbox"/>	<input type="checkbox"/>	Intelence (ETR)	
<input type="checkbox"/>	<input type="checkbox"/>	Invirase (SQV)		<input type="checkbox"/>	<input type="checkbox"/>	Isentress (RAL)		<input type="checkbox"/>	<input type="checkbox"/>	Isentress HD (RAL)	
<input type="checkbox"/>	<input type="checkbox"/>	Juluca (DTG/RPV)		<input type="checkbox"/>	<input type="checkbox"/>	Kaletra (LPV/r)		n/a	<input type="checkbox"/>	Lamivudine/Tenofovir (3TC/TDF)	
<input type="checkbox"/>	<input type="checkbox"/>	Lexiva (FPV)		<input type="checkbox"/>	<input type="checkbox"/>	Norvir (ritonavir)		<input type="checkbox"/>	<input type="checkbox"/>	Odefsey (RPV/FTC/TAF)	
<input type="checkbox"/>	<input type="checkbox"/>	Pifeltro (DOR)		<input type="checkbox"/>	<input type="checkbox"/>	Prezcobix (DRV/c)		<input type="checkbox"/>	<input type="checkbox"/>	Prezista (DRV)	
<input type="checkbox"/>	<input type="checkbox"/>	Reyataz (ATV)		<input type="checkbox"/>	<input type="checkbox"/>	Selzentry (MVC)		<input type="checkbox"/>	<input type="checkbox"/>	Stribild (c/EVG/FTC/TDF)	
<input type="checkbox"/>	<input type="checkbox"/>	Sustiva (EFV)		n/a	<input type="checkbox"/>	Symfi (EFV/3TC/TDF)		n/a	<input type="checkbox"/>	Symtuza (c/DRV/FTC/TAF)	
<input type="checkbox"/>	<input type="checkbox"/>	Tivicay (DTG)		<input type="checkbox"/>	<input type="checkbox"/>	Triumeq (DTG/ABC3TC)		<input type="checkbox"/>	<input type="checkbox"/>	Trizivir (AZT/ABC/3TC)	
<input type="checkbox"/>	<input type="checkbox"/>	Truvada (FTC/TDF)		<input type="checkbox"/>	<input type="checkbox"/>	Viracept (NFV)		<input type="checkbox"/>	<input type="checkbox"/>	Viramune XR (NVP)	
<input type="checkbox"/>	<input type="checkbox"/>	Viread (TDF)		<input type="checkbox"/>	<input type="checkbox"/>	Ziagen (ABC)		<input type="checkbox"/>	<input type="checkbox"/>	zidovudine (AZT)	