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 (mm/dd/yyyy): _____ Social Security Number: _____

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** (mm/dd/yyyy)**:**	**Current CD4 Count:**	**Test Date** (mm/dd/yyyy)**:**

***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, Prezcobix, Truvada, and Juluca each count as 2 ARVs; Atripla, Complera, Odefsey, Trizivir, Triumeq, Biktarvy, and 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: _____

Phone: _____ 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)	
30 day			**30 day**			**30 day**	
☐	**azithromycin**	**OR**	☐	**Clarithromycin**			*(choose one)*
☐	**Dapsone**	**OR**	☐	**pentamidine**	**OR**	☐	**SMZ/TMP** *(choose one)*
☐	**acyclovir**	**OR**	☐	**famciclovir**	**OR**	☐	**Valacyclovir** *(choose one)*
☐	**Gynazole** (butoconazole)	**OR**	☐	**Monistat** (tioconazole)	**OR**	☐	**terconazole** topical *(choose one)*
☐	**fluconazole**	**OR**	☐	**itraconazole**	**OR**	☐	**Voriconazole** *(choose one)*
☐	**atovaquone** (Mepron)					☐	**clindamycin**
☐	**clotrimazole troche**					☐	**Daraprim** (pyrimethamine)
☐	**ethambutol**					☐	**Isoniazid**
☐	**leucovorin** calcium tablets					☐	**megesterol acetate** oral susp
☐	**nystatin** oral susp					☐	**Oravig** (miconazole)
☐	**prednisone**					☐	**primaquine phosphate**
☐	**rifampin**					☐	**rifabutin**
☐	**sulfadiazine**					☐	**Valcyte** (valganciclovir)

ANTIRETROVIRALS RX: MONTHLY CLIENT LIMIT OF FOUR ANTIRETROVIRALS (ARVs)

30 day		**30 day**		**30 day**	
☐	**Aptivus** (TPV)	☐	**Atripla** (ABC/FTC/TDF)	☐	**Biktarvy** (BIC/FTC/TAF)
☐	**Biktarvy pedi** (BIC/FTC/TAF)	☐	**Combivir** (AZT/3TC)	☐	**Complera** (FTC/RPV/TDF)
☐	**Delstrigo** (DOR/3TC/TDF)	☐	**Descovy** (FTC/TAF)	☐	**Dovato** (DTG/3TC)
☐	**Edurant** (RPV)	☐	**Emtriva** (FTC)	☐	**Epivir** (3TC)
☐	**Epzicom** (ABC/3TC)	☐	**Evotaz** (ATV/c)	☐	**Genvoya** (c/EVG/FTC/TAF)
☐	**Intelence** (ETR)	☐	**Invirase** (SQV)	☐	**Isentress** (RAL)
☐	**Isentress pedi** (RAL)	☐	**Isentress HD** (RAL)	☐	**Juluca** (DTG/RPV)
☐	**Kaletra** (LPV/r)	☐	**Lamivudine/Tenofovir** (3TC/TDF)	☐	**Lexiva** (FPV)
☐	**Norvir** (ritonavir)	☐	**Odefsey** (RPV/FTC/TAF)	☐	**Pifeltro** (DOR)
☐	**Prezcobix** (DRV/c)	☐	**Prezista** (DRV)	☐	**Reyataz** (ATV)
☐	**Rukobia ER** (fostemsavir)	☐	**Selzentry** (MVC)	☐	**Stribild** (c/EVG/FTC/TDF)
☐	**Sustiva** (EFV)	☐	**Symfi** (EFV/3TC/TDF)	☐	**Symtuza** (c/DRV/FTC/TAF)
☐	**Tivicay** (DTG)	☐	**Triumeq** (DTG/ABC3TC)	☐	**Triumeq pedi** (DTG/ABC3TC)
☐	**Trizivir** (AZT/ABC/3TC)	☐	**Truvada** (FTC/TDF)	☐	**Viracept** (NFV)
☐	**Viramune XR** (NVP)	☐	**Viread** (TDF)	☐	**Ziagen** (ABC)
☐	**Zidovudine** (AZT)				