

This form is not the appropriate form for Fuzeon, Selzentry, or Serostim submissions.

Note: Form must be completed in full. An incomplete form may be returned.

Desirientis Mediesid ID#	Data of Divide /	ANA/DD (VVVVV)
Recipient's Medicaid ID#	Date of Birth (I	
Davida F. II Nama		
Recipient's Full Name		
Prescriber's Full Name		
Prescriber's NPI		
Prescriber Phone Number		Prescriber Fax Number
Drug	Quantity	Dosage and Frequency of Dosage
HIV Diagnosis Verification OR Prophylaxis for HIV		
Diagnosis / Indication for therapy:		
☐ Maternal-fetal prophylaxis		
☐ Sexual Assault (non-occupational exposure prophylaxis)		
☐ HIV (Specify Diagnosis Code):		
☐ Pre-Exposure HIV Prophylaxis		
Other:		
override to allow time for diagnose	s codes to be updated	HIV diagnosis will be allowed a one-month in the billing process or for this verification through solutions have been implemented to
		fetal prophylaxis and assault victims.
Prescriber's Signature:		Date:
Providers must retain copies of all docu	mentation for five years.	

Fax completed prior authorization request form to Aetna Better Health of Florida at 855-799-2554 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

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