

FLORIDA MEDICAID PRIOR AUTHORIZATION

HIV Diagnosis Verification or Prophylaxis For HIV

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.

Recipient's Medicaid ID#	Date of Birth (M	IM/DD/YYYY)	
Recipient's Full Name			
Prescriber's Full Name			
Prescriber's NPI]		
Prescriber Phone Number		Prescriber Fax Number	
Drug	Quantity	Dosage and Frequency of Dos	sage
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:			
one-month override to allow time for verification form to be submitted with the submitted	r diagnoses codes to be th medical records to Me	rattest to an HIV diagnosis will be allow e updated in the billing process or for the edicaid. Technology solutions have be eaternal-fetal prophylaxis and assault v	his en
Prescriber's Signature:		Date:	
Providers must retain copies of all documentation for five years.			

Mail or Fax Information to:

Fax: 877-614-1078

Magellan Medicaid Administration, Inc. Prior Authorization P. O. Box 7082 Tallahassee, FL 32314-7082 Phone: 877-553-7481

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