



October 2020

The Ohio HIV Drug Assistance Program (OHDAP) is the payer of last resort and covers the cost of prescription medications, except those noted on the exclusions listed below. Individuals accessing medications, must enroll in OHDAP and meet eligibility requirements: HIV diagnosis, Ohio residency, and income at or below 500% of the federal poverty level. Individuals with primary health coverage (e.g., Medicaid, Medicare, or private insurance) may enroll in OHDAP to receive assistance with health insurance premiums and/or copayments. Some medications on the formulary (noted below) may require a prior authorization. For authorization guidance, please contact the OHDAP Coordinators at 1-800-777-4775.

**OHDAP Formulary Exclusion List (not all-inclusive)**

Abortifacients [e.g., mifepristone (Korlym<sup>®</sup>, Mifeprex<sup>®</sup>)]

Acne Medications- [e.g., tretinoin (Retin-A<sup>®</sup>), benzoyl peroxide (Benzoyl<sup>®</sup>), isotretinoin (Zenatane<sup>®</sup>), etc.]

Botulinum Toxin (e.g., Botox<sup>®</sup>, Myobloc<sup>®</sup>, etc.)

Chemotherapeutic Agents [EXCEPT imiquimod cream 5% (Aldara<sup>®</sup>)]

Controlled Substances: Class Schedules II, III, IV, and V [EXCEPT pregabalin (Lyrica<sup>®</sup>), topical testosterone]

Cosmetic Medications/ Hair Removal/Growth Medications [e.g., minoxidil topical (Rogaine<sup>®</sup>)]

Durable Medical Equipment

EGRIFTA SV<sup>®</sup>

Fertility Medications- [e.g., clomiphene (Clomid<sup>®</sup>), menotropins for injection (Menopur<sup>®</sup>), follitropin beta for injection (Follistem<sup>®</sup>), etc.]

Finasteride [Propecia<sup>®</sup>, finasteride oral (Proscar<sup>®</sup>) for treatment of benign prostatic hyperplasia is permitted]

Hepatitis C Treatments

Herbal Medications

Human Growth Hormone [e.g., gonadotropin, somatropin, (Norditropin<sup>®</sup>)]

Hyaluronic Acid Derivatives [e.g., Restylane, Juvoderm; Calcium hydroxylapatite (Radiesse); Poly-L-Lactic Acid (Sculptra); Polymethylmethacrylate (Bellafill)]

Injectable Muscle Relaxants [e.g., orfenadrine (Norflex<sup>®</sup>)]

Sexual Dysfunction Medications [e.g., sildenafil (Viagra<sup>®</sup>), tadalafil (Cialis<sup>®</sup>), flibanserin (Addyi<sup>®</sup>), etc.]

**Prior Authorizations:**

Trogarzo<sup>®</sup> (ibalizumab-uiyk)

Rukobia<sup>®</sup> (fostemsavir)

**Other Special Provisions:**

Diabetic supplies (e.g., test strips, lancets, alcohol pads, etc.) are covered; syringes may only be provided for insulin injection

Vaccinations approved by the Advisory Committee on Immunization Practices (ACIP) are covered

**Antiretrovirals Removed from the Formulary:**

As of January 1, 2020, OHDAP removed the following therapies:

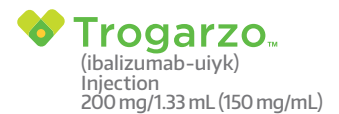
Protease Inhibitors: Fosamprenavir (Lexiva), Indinavir (Crixivan), Nelfinavir (Viracept), and Saquinavir (Invirase)

Nucleoside Reverse Transcriptase Inhibitors: Stavudine (Zerit) and Didanosine (Videx and Videx EC)

Non-Nucleoside Reverse Transcriptase Inhibitors: Delavirdine (Rescriptor)



# TROGARZO™ Enrollment Form



**To enroll, Fax all documents to 1-855-836-3069.**

Please ensure all sections of Form are completed in full, with supporting documents included.

Questions? Contact a Patient Care Coordinator at 1-833-23-THERA (1-833-238-4372), Mon-Fri 8AM-8PM ET

## 1. Patient Information

First Name \_\_\_\_\_ Date of Birth MM / DD / YY Gender  M  F  
Last Name \_\_\_\_\_ Preferred Language  English  Other \_\_\_\_\_  
Address \_\_\_\_\_ Telephone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Email \_\_\_\_\_  
ZIP \_\_\_\_\_ SSN (last 4 digits) \_\_\_\_\_ Best time to contact  AM  PM  Other \_\_\_\_\_

Alternate Contact/Caregiver \_\_\_\_\_ Telephone \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  OK to leave message

## 2. Prescriber Information

First Name \_\_\_\_\_ NPI # \_\_\_\_\_  
Last Name \_\_\_\_\_ Tax ID # \_\_\_\_\_  
Specialty \_\_\_\_\_ Medicaid # \_\_\_\_\_  
Office/Clinic/Institution \_\_\_\_\_ Office Contact \_\_\_\_\_  
Address \_\_\_\_\_ Office Telephone \_\_\_\_\_  
City \_\_\_\_\_ Office Fax \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_ Office Email \_\_\_\_\_

## 3. Prescription

**Rx: TROGARZO™** (Ibalizumab-uiyk)  
NDC: 62064-122-02

**Loading Dose:** 1 dose of 2,000 mg (10 vials)  
IV infusion over 30 minutes

**Prescription Type:**

New  Continuing Therapy  Restart

**Maintenance Dose:** 800 mg (4 vials)  
IV infusion over 15 minutes, every 2 weeks for \_\_\_\_\_ doses  
Quantity:  8 Vials (1 month supply)  Other \_\_\_\_\_  Refills \_\_\_\_\_

Diagnosis (ICD-10):  B20  Other \_\_\_\_\_

Drug/Food Allergies \_\_\_\_\_  NKDA

Anaphylaxis Medications: Per pharmacy protocol for treatment infusion-related adverse reactions

Fluids for Reconstitution/Administration:  0.9% NaCl 250 mL  0.9% NaCl Flush 10 mL

Medication History Included  
Please attach complete antiretroviral list along with concomitant medication history

## 4. Prescriber Authorization and Signature

I certify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge. I have prescribed TROGARZO™ based on my judgment of medical necessity and I will be supervising the patient's treatment. I have received the necessary authorization prior to the transmittal of health information to Theratechnologies Inc., and parties working with Theratechnologies Inc., to perform a preliminary assessment of insurance verification and determine patient eligibility for the THERA patient support™ program. I authorize the forwarding of this prescription to a dispensing specialty pharmacy on behalf of myself and the patient. I understand that neither I nor the patient should seek reimbursement for any free product received under the program.

**Special Note:** The physician is to comply with their state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance of state-specific requirements could result in outreach to the prescriber.

### Select one option:

Prescriber's Signature (no stamps; **Dispense As Written**) \_\_\_\_\_ Date MM / DD / YY

### OR

Prescriber's Signature (no stamps; **Substitution Permissible**) \_\_\_\_\_ Date MM / DD / YY

## 5. Insurance Information

Patient does not have insurance

**OR**

Patient has insurance

Please complete the information below and include copies of front and back of insurance card(s)

Primary Medical Insurance \_\_\_\_\_ Policy # \_\_\_\_\_

Cardholder Name \_\_\_\_\_ Cardholder Date of Birth MM / DD / YY

Relationship to Cardholder \_\_\_\_\_

Secondary Medical Insurance \_\_\_\_\_ Policy # \_\_\_\_\_

Cardholder Name \_\_\_\_\_ Cardholder Date of Birth MM / DD / YY

Relationship to Cardholder \_\_\_\_\_

Prescription Drug Insurer/Pharmacy Benefit Manager (PBM) \_\_\_\_\_

Telephone \_\_\_\_\_ Policy # \_\_\_\_\_

Rx BIN # \_\_\_\_\_ Rx Group # \_\_\_\_\_ Rx PCN # \_\_\_\_\_

## 6. Site of Care

**Initial Dose:** (select one option)

Infusion Center \_\_\_\_\_

Prescribing Physician Office \_\_\_\_\_

Home Infusion

**All Subsequent Dosing:** (select one option)

Same as Initial Dose

Different \_\_\_\_\_

Authorization for Ancillary Supplies: Needles, syringes, etc., as needed for administration

Nursing Orders: Provide skilled nursing visit to administer medication, assess patient's status and response to therapy

## 7. Patient Authorization and Signature

### Patient Authorization to Use and Disclose Protected Health Information

I authorize health care providers and their staff involved in my care to disclose my Protected Health Information (as defined below), including but not limited to my medical record and other health information on my completed Statement of Medical Necessity form or other forms, records that may contain information created by other persons, entities, physicians, and health care providers information concerning HIV/AIDS diagnosis and treatment, including HIV test results, as well as information regarding substance use disorder treatment services and mental health services (excluding psychotherapy notes) (collectively, "Protected Health Information"), to Theratechnologies Inc. and its agents, representatives, and direct and indirect service providers (collectively, "Theratechnologies"), so that Theratechnologies may:

1. Facilitate the filling of my prescription for and the delivery and administration of Theratechnologies products, including disclosing or redisclosing Protected Health Information to pharmacies;
2. Assist me in obtaining insurance coverage for Theratechnologies products, including disclosing or redisclosing Protected Health Information to health plans; and
3. Contact me by mail, email, and/or telephone to enroll me in, and administer, programs that provide support services.

In addition, by checking this box, I authorize Theratechnologies to:

4. Provide me with free educational information and marketing materials; and
5. Conduct surveys to measure my satisfaction with Theratechnologies products and services.

To accomplish these purposes, I further authorize Theratechnologies to share information, including HIV/AIDS information, between and among the entities defined in this Authorization as

Theratechnologies. I understand that once my Protected Health Information is disclosed pursuant to this authorization, it may no longer be protected by the federal privacy law and regulations known as "HIPAA" or state privacy laws and may be the subject to further disclosure by Theratechnologies and third parties with whom Theratechnologies may share the information. However, other state and federal laws may prohibit the recipient from disclosing specially protected information such as certain HIV/AIDS-related information, substance use disorder treatment information, and mental health information.

I understand that I may refuse to sign this authorization. My refusal will not affect my ability to receive Theratechnologies products, treatment, payment, enrollment in a health plan, or eligibility for benefits but my refusal may limit my ability to receive certain support services that are provided by Theratechnologies.

I understand that health care providers may receive compensation, remuneration, or other value as a result of their use and disclosure of my Protected Health Information as described in this authorization.

I understand that this authorization will remain in effect for 10 years from the date of my signature, unless limited by state laws and regulations or I revoke it in writing earlier by contacting Theratechnologies c/o THERA patient support™, P.O. Box 390, Somerville, NJ 08876.

If I revoke this authorization, health care providers will stop using and disclosing my Protected Health Information for the purposes outlined in this authorization, but the revocation will not affect prior use or disclosure of my Protected Health Information in reliance on this authorization. I have the right to receive a copy of this authorization after I sign it.

I understand that the support services provided by Theratechnologies that are described in this authorization can be changed at any time, without prior notification.

Patient Name \_\_\_\_\_ Date of Birth MM / DD / YY

Address \_\_\_\_\_ Telephone \_\_\_\_\_

**Patient or Authorized Representative Signature** \_\_\_\_\_ Date MM / DD / YY

If Signed by an Authorized Representative:

Authorized Representative Name \_\_\_\_\_

Basis for Authority \_\_\_\_\_

#### NOTICE TO RECIPIENT OF INFORMATION:

**HIV Related Information:** To the extent that HIV-related information has been provided to you, such information has been disclosed to you from records whose confidentiality may be protected by federal and state law. Such laws may prohibit you from making any further disclosure of the HIV-related information without the specific written consent of the person to whom it pertains, or as otherwise permitted by said laws. When obtaining such written consent, you must expressly identify that HIV-information is being disclosed (a general authorization for the release of the entire medical file, for example is **NOT** sufficient for this purpose). An oral disclosure shall be accompanied or followed by such notice within ten days.

**Ohio HIV Drug Assistance Program (OHDAP)**  
**Application for Prior Authorization of Rukobia (fostemsavir)**

(Click here for full **Rukobia Prescribing Information**)

**Clinical Indications and Usage:**

RUKOBIA, a human immunodeficiency virus type 1 (HIV-1) gp120-directed attachment inhibitor, in combination with other antiretroviral(s), is indicated for the treatment of HIV-1 infection in heavily treatment-experienced adults with multidrug-resistant HIV-1 infection failing their current antiretroviral regimen due to resistance, intolerance, or safety considerations. Rukobia is to be used in combination with other antiretroviral agents.

**To be eligible for assistance for Rukobia, a client must meet the following criteria:**

1. Be currently enrolled in OHDAP and eligible to receive services;
2. Been denied medication coverage by their insurance plan (if applicable). If client has insurance, insurance will be billed first and if denied, OHDAP will coordinate benefits;
3. Have a history of multi-drug resistant HIV infection;
4. Attach documentation of resistance in at least two-drug classes.

**Complete the following:**

Applicant's Name \_\_\_\_\_  
Legal First Middle Last

Social Security Number: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Provider Name: \_\_\_\_\_ Clinic: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Medical Provider Signature: \_\_\_\_\_

**Provider must acknowledge the following with initials:**

\_\_\_\_\_ Patient has been counseled on the high cost of treatment and is willing to be 100% adherent to treatment regimen.

Submit completed form to: Ohio Department of Health –OHDAP or Fax to: 800-448-6337  
246 N. High Street, 6<sup>th</sup> floor  
Columbus, OH 43215

**OHDAP USE ONLY:** Authorization Approved?  YES  NO Authorization Number: \_\_\_\_\_

Authorization Effective Date: \_\_\_\_\_ Authorization Expiration Date: \_\_\_\_\_

Based on OHDAP eligibility