

*** Notation: RYAN WHITE PROGRAM PRESCRIPTION DRUG FORMULARY COMMENTS**

Revised: 8/10/2009

A	Medications available through the federal AIDS Drug Assistance Program (ADAP) through the Miami-Dade County Health Department. These drugs are available to clients fulfilling the ADAP eligibility requirements.
B	In order for a client to obtain this medication through the Part A or MAI Programs, one of the two conditions (histoplasmosis or aspergillosis) <u>must</u> have been identified and documented in the client's chart by his/her physician. In addition, the Ryan White Sporanox Letter of Medical Necessity is required. Part A or MAI funds may <u>only</u> be used to cover one of the two conditions. (Rev. 5/12/2008)
C	The Ryan White Nutritional Supplements Letter of Medical Necessity is required. Part A or MAI funds may only be used to reimburse for nutritional supplements for the treatment of indications experienced by HIV+ children 18 years and under (for Boost Liquid) and HIV+ children 1-10 years of age (for Resource Just for Kids). These nutritional supplements are only available in liquid form and require a referral from both a Physician and a Nutritionist.
D	These nutritional supplements are available in powder form only and require a referral from both a Physician and a Nutritionist.
E	(Notation no longer applicable.)
F	Part A or MAI funds may only be used to reimburse for this medication for the treatment of Toxoplasmosis, and must be written as such on the prescription.
G	The Ryan White Appetite Stimulant Letter of Medical Necessity is required, and the need for this medication must be reassessed monthly. Part A or MAI funds may only be used to cover one (1) b.i.d. dosage, 2.5 m.g. of Dronabinol (Marinol).
H	To qualify for Part A or MAI coverage, the patient's testosterone level must be below a normal reading. Prescribing physicians must include the patient's most recent testosterone level on the prescription for this medication. If this information is not provided on the prescription, Part A or MAI will not cover the cost of this medication.
I	Part A or MAI funds may <u>only</u> be used to reimburse for these medications for the treatment of insulin dependent diabetes mellitus secondary to HIV treatment, and must be written as such on the prescription.
J	Part A or MAI funds may only be used to reimburse for these medications for the treatment of indications experienced by HIV+ children 12 years and under. These medications are only available in liquid or suspension form.
K	In order for a patient to obtain this medication through the Part A or MAI Programs, one of the following conditions must have been identified and documented in the patient's chart by his/her physician: (1) patient has acute Herpes Zoster, and requires Valacyclovir 1000mg three (3) times daily; or, (2) patient requires Valacyclovir daily suppressive therapy for recurrent Herpes Simplex episodes occurring while receiving standard doses of daily suppressive Acyclovir therapy. To qualify for daily suppressive Valacyclovir therapy, the patient must have had more than one Herpes recurrence while receiving daily Acyclovir suppressive therapy. This must be documented by attaching a photocopy of a recent Acyclovir prescription to the Letter of Medical Necessity submitted with the first prescription for Valacyclovir tablets. This is not required on subsequent refills. Part A funds may <u>only</u> be used to pay for this medication if the patient is suffering from one of the two conditions specified above.
L	In order to receive Eprosartan (Teveten) through the Ryan White Part A or MAI Programs, the patient must have had a prior history of intolerability to the use of Angiotensin Converting Enzyme (ACE) Inhibitors.
M	(Notation no longer applicable.)
N	(Notation no longer applicable.)
O	(Notation no longer applicable.)
P	Ofloxacin (Ocuflox) is restricted to ophthalmologist use only.
Q	Physicians prescribing Neupogen to patients needing to access Part A or MAI pharmaceutical services are required to complete a Ryan White Program Prior Authorization Form for Neupogen (Filgrastim). Prescribing physicians must submit the Ryan White Program Prior Authorization Form to the Part A or MAI pharmacy along with the original prescription and lab results dated within the last two (2) months.
R	Physicians prescribing Procrit or Epogen to patients needing to access Part A or MAI pharmaceutical services are required to complete a Ryan White Program Prior Authorization Form for Procrit or Epogen (Epoetin Alpha). Prescribing physicians must submit the Ryan White Program Prior Authorization Form to the Part A or MAI pharmacy along with the original prescription and lab results dated within the last two (2) months.
S	There is no generic equivalent for this new brand name product.

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T	<p>Effective June 20, 2005, Quetiapine (Seroquel) is restricted to strengths no lower than 200mg. Therefore, only 200mg, 300mg dosing strengths will be filled.</p>
U	<p>The Ryan White Program Letter of Medical Necessity for Enfuvirtide (Fuzeon) is required. The primary medical provider must certify, it to be medically necessary to add Enfuvirtide (Fuzeon) to this patient's antiretroviral regimen. The patient has been on Enfuvirtide (Fuzeon) through another funding source but this funding source is no longer available. This condition necessitates Ryan White Part A or MAI coverage for continuity of care. In addition, the patient must meet one (1) of the following appropriate criteria below:</p> <ol style="list-style-type: none"> 1. The patient is eligible for the AIDS Drug Assistance Program (ADAP) and there is a completed application pending approval. A new prescription is allowed for a maximum of 60 days and no refill authorizations are accepted; <p style="text-align: center;">OR</p> <ol style="list-style-type: none"> 2. The patient is not eligible for ADAP and must be covered under Ryan White Part A or MAI pending another payment source. A new prescription is allowed for a maximum of 90 days and no refill authorizations are accepted.
V	<p>The Ryan White Program Letter of Medical Necessity for Tipranavir (Aptivus) is required. As the prescribing healthcare provider, it is his/her considered opinion that Tipranavir (Aptivus) is medically necessary for the patient, and should be added to his/her antiretroviral regimen. In addition, as the prescribing healthcare provider, hereby certify that the following criteria have been met:</p> <ol style="list-style-type: none"> 1. The patient has failed treatment with Lopinavir/ritonavir (Kaletra) and all three classes of antiretrovirals; <p style="text-align: center;">OR</p> <ol style="list-style-type: none"> 2. I have fully discussed all issues and consequences related to non-adherence with the patient.
W	<p>REVISED This medication was added to the Ryan White Program Prescription Drug Formulary effective March 1, 2008. Before prescribing Maraviroc (Selzentry) to any client, physicians and other prescribing clinicians must complete a Letter of Medical Necessity for the Trofile Co-Receptor Tropism Assay (billing encounter code: TROF). Providers must adhere to the "Sample Collection and Handling Requirements for PhenoSense™ HIV, GeneSeq™ HIV, PhenoSense GT™, PhenoSense™ Entry, and Trofile™ Co-Receptor Tropism Assays," when obtaining the specimen for delivery to the laboratory. A Letter of Medical Necessity for Selzentry (Maraviroc) is also required prior to dispensing the medication.</p>
X	<p>This medication was added to the Ryan White Program Prescription Drug Formulary effective March 1, 2008. The Florida Department of Health issued and Interoffice Memorandum, dated January 31, 2008, with information regarding Intelence (Etravirine). Accompanying this Memorandum was a document titled "Intelence (Etravirine) Tablets - Full Prescribing Information." This information comes from the manufacturer. It is extremely important for providers and clients to understand the prescribing information related to Intelence (Etravirine).</p>