Ryan White Program
Service Delivery Guidelines
Fiscal Year 2019
(Year 29)

Section V –
Letters of Nutritional Assessment and Medical Necessity

Miami-Dade County
Office of Management and Budget
Grants Coordination

RYAN WHITE PROGRAM
Letter of Medical Necessity to Accompany Prescription for Tipranavir (Aptivus®)

Date: _____

As the prescribing healthcare provider for _____, I consider it to be medically necessary to add Tipranavir (Aptivus®) to this patient's antiretroviral regimen.

In addition, I hereby certify that the following criteria have been met:

1. The patient has failed treatment with Lopinavir/ritonavir (Kaletra®) and all three classes of antiretrovirals;

-AND-

2. I have fully discussed all issues and consequences related to non-adherence with the patient.

Sincerely,

_____, M.D.

_____ _____
Print Physician's name Florida medical license # (ME#)

_____ _____
Patient's 10 digit Medicaid # (if applicable) Patient's CIS # (assigned by the Ryan White Program Service Delivery Information System)

Please note: All questions should be directed to the Office of Management and Budget-Grants Coordination/Ryan White Program, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.). Pursuant to the most current Professional Service Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

Rev. 3/1/2014

RYAN WHITE PROGRAM
Letter of Medical Necessity to Accompany Prescription for Enfuvirtide (Fuzeon®)

Date: _____

As the primary medical provider for _____, I consider it to be medically necessary to add Enfuvirtide (Fuzeon®) to this patient's antiretroviral regimen.

This patient has been on Enfuvirtide (Fuzeon®) through another funding source but this funding source is no longer available. This condition necessitates Ryan White Program coverage for continuity of care.

In addition, the patient meets one (1) of the following (check-off the appropriate criteria below):

☐ 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.

-OR-

☐ The patient is not eligible for ADAP and must be covered under the Ryan White Program pending another payment source. A new prescription is allowed for a maximum of **90 days** and no refill authorizations are accepted.

_____, M.D.

_____ _____
Print M.D.'s name Florida medical license # (ME#)

_____ _____
Patient's 10 digit Medicaid # (if applicable) Patient's CIS # (assigned by the Ryan White Program Service Delivery Information System)

Please note: All questions should be directed to the Office of Management and Budget-Grants Coordination/Ryan White Program, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.). Pursuant to the most current Professional Service Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

LAB TEST

RYAN WHITE PROGRAM
Letter of Medical Necessity for the Highly Sensitive Tropism Assay required to prescribe Maraviroc (Selzentry ®)

(Required only when the cost of the assay is not covered by any other funding source.)

Date: _____

As the primary care physician treating_____, I intend to add Maraviroc (Selzentry) to this patient's antiretroviral regimen which will contain the following two other agents: _____ and _____.

I certify the client (patient) is not eligible for any other payment source;

I understand the Highly Sensitive Tropism Assay may only be ordered under the following conditions:

1. The above criterion has been met and is fully documented in the patient's medical record;

2. Adherence has been discussed with the patient on an on-going basis as part of his/her medical treatment, and it has been determined that the patient is satisfactorily adherent with his/her current ART regimen;

   and

3. Patient does not have a history of dual/mixed tropism.

Sincerely,

_____, MD/DO/ARNP/PA

_____ Print MD/DO/ARNP/PA name

_____ Florida medical license # (ME#)

_____ Patient's 10 digit Medicaid # (if applicable)

_____ Patient's CIS # (assigned by the Ryan White Program Service Delivery Information System)

Please note: All questions should be directed to the Office of Management and Budget-Grants Coordination/Ryan White Program, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.). Pursuant to the most current Professional Service Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

Rev. 4/29/2019

RYAN WHITE PROGRAM
Letter of Medical Necessity for Neupogen® (Filgrastim)

Recipient's Full Name:_____ Date of Birth: _____ /_____ /_____

Prescriber Full Name:_____ Prescriber License #: (MD,OS,RN)_____

Prescriber Telephone #:_____ Prescriber Fax #:_____

Drug Strength: _____

Please check below the diagnosis or indication for this product:

☐ Severe neutropenia in AIDS patients on antiretroviral therapy

☐ Severe Chronic Neutropenia: ☐ congenital ☐ cyclic ☐ idiopathic

☐ Cancer patients with HIV/AIDS receiving myelosuppressive chemotherapy

Select one of the following:

New Therapy ☐ **OR** Continuation of Therapy ☐

Lab Test Date: _____ Absolute Neutrophil Count: _____ cells/mm3

What is the date range of therapy? Begin Date: _____ End Date: _____

Indicate dosage and frequency of dosing: _____

Prescriber's Signature: _____

Please attach a copy of the original prescription and lab results dated within the last two (2) months.

Fax information to:

Ryan White Program-funded Pharmacy	Phone Number	Fax Number
AIDS Healthcare Foundation (NW 170th St.)	(305) 758-1984	(305) 758-8714
AIDS Healthcare Foundation (Biscayne Blvd.)	(305) 764-3780	(305) 764-3784
AIDS Healthcare Foundation (Miami Beach)	(305) 538-5914	(305) 538-1730
AIDS Healthcare Foundation (S. Miami Ave.)	(305) 534-1294	(305) 534-8311
Citrus Health Network	(305) 825-0300, Ext. 2770	(305) 556-2580
Community Health of South Florida (Doris Ison)	(305) 253-5100	(305) 254-7795
Community Health of South Florida (MLKJCC)	(305) 248-4334	(305) 246-1016
Miami Beach Community Health Ctr (Alton Rd.)	(305) 538-8835, Option 41	(305) 695-2156
Miami Beach Community Health Ctr. (Bev. Press)	(305) 538-8835, Option 42	(305) 867-4312
Miami Beach Community Health Ctr. (North)	(305) 538-8835, Option 43	(305) 695-2168
Public Health Trust / Jackson Health System	(305) 585-5890	(305) 585-0088

Please note: All questions should be directed to the Office of Management and Budget-Grants Coordination/Ryan White Program, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.). Pursuant to the most current Professional Service Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

Rev. 3/1/2014

RYAN WHITE PROGRAM
Letter of Medical Necessity for Procrit® or Epogen® (both Epoetin Alpha)

Recipient's Full Name:_____ Date of Birth: _____ /_____ /_____

Prescriber Full Name:_____ Prescriber License #: (MD,OS,RN)_____

Prescriber Telephone #:_____ Prescriber Fax #:_____

Drug Strength: _____

Please check below the diagnosis or indication for this product:

☐ Anemia associated with HIV

☐ Anemia associated with renal failure if patient is not on dialysis

☐Anemia associated with chemotherapy

☐Other _____

Select one of the following:

New Therapy ☐ **OR** Continuation of Therapy ☐

Does the patient have active gastrointestinal bleeding? ☐ YES **OR** ☐ NO

Lab Test Date:_____ Hematocrit:_____% Hemoglobin:_____g/dl

Indicate dosage and frequency of dosing: _____

Prescriber's Signature: _____

Please attach a copy of the original prescription and lab results dated within the last two (2) months.

Fax information to:

Ryan White Program-funded Pharmacy	Phone Number	Fax Number
AIDS Healthcare Foundation (NW 170th St.)	(305) 758-1984	(305) 758-8714
AIDS Healthcare Foundation (Biscayne Blvd.)	(305) 764-3780	(305) 764-3784
AIDS Healthcare Foundation (Miami Beach)	(305) 538-5914	(305) 538-1730
AIDS Healthcare Foundation (S. Miami Ave.)	(305) 534-1294	(305) 534-8311
Citrus Health Network	(305) 825-0300, Ext. 2770	(305) 556-2580
Community Health of South Florida (Doris Ison)	(305) 253-5100	(305) 254-7795
Community Health of South Florida (MLKJCC)	(305) 248-4334	(305) 246-1016
Miami Beach Community Health Ctr (Alton Rd.)	(305) 538-8835, Option 41	(305) 695-2156
Miami Beach Community Health Ctr. (Bev. Press)	(305) 538-8835, Option 42	(305) 867-4312
Miami Beach Community Health Ctr. (North)	(305) 538-8835, Option 43	(305) 695-2168
Public Health Trust / Jackson Health System	(305) 585-5890	(305) 585-0088

Please note: All questions should be directed to the Office of Management and Budget-Grants Coordination/Ryan White Program, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.). Pursuant to the most current Professional Service Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

RYAN WHITE PROGRAM
Letter of Medical Necessity
for Roxicodone (Oxycodone) and Percocet (Oxycodone/APAP)

Date:_____

As the primary care physician treating _____and in accordance with **F.A.C. 64B8-9.013** [1] it is my considered opinion that (check **one** of the following)

☐ Roxicodone (Oxycodone)

☐ Percocet (Oxycodone/APAP) 5/325 *generic only*

The patient's diagnosis for this medication is _____. This diagnosis is related to the patient's HIV/AIDS status, complication of HIV or HIV-related co-morbidity because: _____. The above medication will be prescribed for _____ (length of time) at a strength of _____ with a frequency of _____ (e.g., bid).

- I have documented that other pain medications have been used and have failed or were not tolerated.
- I have discussed the issue of dependency with the patient.

I attest the above conditions have been met and are fully documented in the patient's medical record.

Sincerely,

_____, M.D./D.O.

_____	_____
Print M.D./D.O. name	Florida Medical License # (ME#)
_____	_____
Patient's 10 Digit Medicaid # (if applicable)	Patient's CIS # (ID number assigned by the Ryan White Program Service Delivery Information System)

Please note: All questions should be directed to the Office of Management and Budget-Grants Coordination/Ryan White Program, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.). Pursuant to the most current Professional Service Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

Partnership Approved 10/16/2017

[1] Florida Administrative Code 64B8-9.013 Standards for the Use of Controlled Substances for the Treatment of Pain. Specific Authority Florida Statute 458.309 and 458.331.

64B8-9.013 Standards for the Prescribing of Controlled Substances for the Treatment of Acute Pain.

The standards of practice in this rule do not supersede the level of care, skill and treatment recognized in general law related to healthcare licensure. All physicians and physician assistants who are authorized to prescribe controlled substances shall comply with the following:

(1) Definitions.

(a) Acute Pain. For the purpose of this rule, "acute pain" is defined as the normal, predicted, physiological, and time-limited response to an adverse chemical, thermal, or mechanical stimulus associated with surgery, trauma, or acute illness. The term does not include pain related to:

1. Cancer.

2. A terminal condition. For purposes of this subparagraph, the term "terminal condition" means a progressive disease or medical or surgical condition that causes significant functional impairment, is not considered to be reversible without the administration of life-sustaining procedures, and will result in death within 1 year after diagnosis if the condition runs its normal course.

3. Palliative care to provide relief of symptoms related to an incurable, progressive illness or injury.

4. A traumatic injury with an Injury Severity Score of 9 or greater.

(b) Prescription Drug Monitoring Program (PDMP) or "the system." For the purpose of this rule, the prescription drug monitoring system is defined as the Florida Department of Health's electronic system to collect and store controlled substance dispensing information as set forth in section 893.055, F.S.

(c) Substance Abuse. For the purpose of this rule, "substance abuse" is defined as the use of any substances for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.

(2) Standards. The nature and extent of the requirements set forth below will vary depending on the practice setting and circumstances presented to the clinician. The Board has adopted the following standards for the prescribing of controlled substances for acute pain:

(a) Evaluation of the Patient. A medical history and physical examination appropriate for the patient's clinical condition must be conducted and documented in the medical record. The medical record also shall document the presence of one or more recognized medical indications for the use of a controlled substance.

(b) Treatment Plan. The written treatment plan shall indicate if any further diagnostic evaluations or other treatments are planned including non-opioid medications and therapies if indicated. After treatment begins, the physician shall adjust medication therapy, if necessary, to the individual medical needs of each patient.

(c) Informed Consent and Agreement for Treatment. The physician shall discuss the risks and benefits of the use of controlled substances including the risk of abuse and addiction as well as physical dependence with the patient, persons designated by the patient, or with the patient's surrogate or guardian if the patient is incompetent. The discussion shall also include expected pain intensity, duration, options, use of pain medications, non-medication therapies, and common side effects. Special attention must be given to those pain patients who are at risk of misuse or diversion of their medications.

(d) Periodic Review. Based on the circumstances presented, the physician shall review the course of treatment and any new information about the etiology of the pain. Continuation or modification of therapy shall depend on the physician's evaluation of the patient's progress. If treatment goals are not achieved, despite medication adjustments, the physician shall reevaluate the patient and determine the appropriateness of continued treatment. The physician shall monitor patient compliance of medication usage and related treatment plans.

(e) Consultation. The physician shall refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder requires extra care, monitoring, and documentation, and may require consultation with or referral to an expert in the management of such patients.

(f) Medical Records. The physician is required to keep accurate and complete records to include, but not be limited to:

1. The medical history and a physical examination, including history of drug abuse or dependence, if indicated;

2. Diagnostic, therapeutic, and laboratory results;

3. Evaluations and consultations;

4. Treatment objectives;

5. Discussion of risks and benefits;

6. Treatments;

7. Medications (including date, type, dosage, and quantity prescribed);

8. Instructions and agreements;

9. Drug testing results if indicated;

10. Justification for deviation from the 3-day prescription supply limit for a Schedule II opioid controlled substance for acute pain;

11. Outline of problems encountered when attempting to consult the Prescription Drug Monitoring Program (PDMP) or its successor, if the system was non-operational or the clinician, or his or her designee, is unable to access the PDMP due to a temporary technological or electrical failure; and

12. Periodic reviews. Records must remain current, maintained in an accessible manner, readily available for review, and must be in full compliance with rule 64B8-9.003, F.A.C., section 456.057, F.S., and section 458.331(1)(m), F.S.

(g) Compliance with Laws and Rules. Physicians and physician assistants shall at all times, remain in compliance with this rule and all state and federal laws and regulations addressing the prescribing and administration of controlled substances.

Rulemaking Authority 456.44(4), 458.309(1), 458.331(1)(v) FS. Law Implemented 456.44, 458.326, 458.331(1)(g), (t), (v) FS. History–New 12-21-99, Amended 11-10-02, 10-19-03, 10-17-10, 2-21-19.

64B15-14.005 Standards for the Prescribing of Controlled Substances for Treatment of Acute Pain.

The standards of practice in this rule do not supersede the level of care, skill and treatment recognized in general law related to healthcare licensure. All physicians and physician assistants who are authorized to prescribe controlled substances shall comply with the following:

(1) Definitions.

(a) Acute Pain. For the purpose of this rule, "acute pain" is defined as the normal, predicted, physiological, and time-limited response to an adverse chemical, thermal, or mechanical stimulus associated with surgery, trauma, or acute illness. The term does not include pain related to:

1. Cancer.

2. A terminal condition. For purposes of this subparagraph, the term "terminal condition" means a progressive disease or medical or surgical condition that causes significant functional impairment, is not considered to be reversible without the administration of life-sustaining procedures, and will result in death within 1 year after diagnosis if the condition runs its normal course.

3. Palliative care to provide relief of symptoms related to an incurable, progressive illness or injury.

4. A traumatic injury with an Injury Severity Score of 9 or greater.

(b) Prescription Drug Monitoring Program (PDMP) or "the system". For the purpose of this rule, the system is defined as the Florida Department of Health's electronic system to collect and store controlled substance dispensing information as set forth in section 893.055, F.S.

(c) Substance Abuse. For the purpose of this rule, "substance abuse" is defined as the use of any substances for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.

(2) Standards. The nature and extent of the requirements set forth below will vary depending on the practice setting and circumstances presented to the clinician. The Board has adopted the following standards for the prescribing of controlled substances for acute pain:

(a) Evaluation of the Patient. A medical history and physical examination appropriate for the patient's clinical condition must be conducted and documented in the medical record. The medical record also shall document the presence of one or more recognized medical indications for the use of a controlled substance.

(b) Treatment Plan. The written treatment plan shall indicate if any further diagnostic evaluations or other treatments are planned including non-opioid medications and therapies if indicated. After treatment begins, the physician shall adjust medication therapy, if necessary, to the individual medical needs of each patient.

(c) Informed Consent and Agreement for Treatment. The physician shall discuss the risks and benefits of the use of controlled substances including the risk of abuse and addiction as well as physical dependence with the patient, persons designated by the patient, or with the patient's surrogate or guardian if the patient is incompetent. The discussion shall also include expected pain intensity, duration, options, use of pain medications, non-medication therapies, and common side effects. Special attention must be given to those pain patients who are at risk of misuse or diversion of their medications.

(d) Periodic Review. Based on the circumstances presented, the physician shall review the course of treatment and any new information about the etiology of the pain. Continuation or modification of therapy shall depend on the physician's evaluation of the patient's progress. If treatment goals are not achieved, despite medication adjustments, the physician shall reevaluate the patient and determine the appropriateness of continued treatment. The physician shall monitor patient compliance of medication usage and related treatment plans.

(e) Consultation. The physician shall refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder requires extra care, monitoring, and documentation, and may require consultation with or referral to an expert in the management of such patients.

(f) Medical Records. The physician is required to keep accurate and complete records to include, but not be limited to:

1. The medical history and a physical examination, including history of drug abuse or dependence, if indicated;

2. Diagnostic, therapeutic, and laboratory results;

3. Evaluations and consultations;

4. Treatment objectives;
5. Discussion of risks and benefits;
6. Treatments;
7. Medications (including date, type, dosage, and quantity prescribed);
8. Instructions and agreements;
9. Drug testing results if indicated;
10. Justification for deviation from the 3-day prescription supply limit for a Schedule II opioid controlled substance for acute pain;
11. Outline of problems encountered when attempting to consult the PDMP, if the system was non-operational or the clinician, or his or her designee, is unable to access the PDMP due to a temporary technological or electrical failure; and
12. Periodic reviews. Records must remain current, maintained in an accessible manner, readily available for review, and must be in full compliance with rule 64B15-15.004, F.A.C., sections 456.057, and 459.015(1)(o), F.S.

(g) Compliance with Laws and Rules. Physicians and physician assistants shall at all times, remain in compliance with this rule and all state and federal laws and regulations addressing the prescribing and administration of controlled substances.

Rulemaking Authority 456.44(4), 459.005(1) FS. Law Implemented 456.44, 459.003(3), 459.015(1)(g), (x), (2) FS. History–New 3-9-00, Amended 11-14-06, 11-10-11, 1-1-19.

RYAN WHITE PROGRAM
Letter of Medical Necessity for Sporanox (Itraconazole)

Date:_____

As the primary care physician treating _____, I consider it medically necessary to prescribe Sporanox (Itraconazole). The medication will be utilized to treat **ONLY** one of the following two conditions (please check one box):

☐	Histoplasmosis
☐	Aspergillosis

The diagnosis above is fully documented in the patient's medical record.

Sincerely,

_____, M.D./D.O.

_____ _____
Print M.D./D.O. name Florida medical license # (ME#)

_____ _____
Patient's 10 digit Medicaid # (if applicable) Patient's CIS # (assigned by the Ryan White Program Service Delivery Information System)

Please note: All questions should be directed to the Office of Management and Budget-Grants Coordination/Ryan White Program, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.). Pursuant to the most current Professional Service Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

Rev. 3/1/2014

RYAN WHITE PROGRAM
Letter of Medical Necessity (LOMN) for Testosterone Supplementation
(A LOMN must accompany each prescription)

Date: _____

As the prescribing practitioner treating_____, I intend to place this patient on testosterone supplementation (duration may NOT exceed 12 months). I have educated the patient on the consequences of testosterone supplementation and have explained the risks associated with this therapy, including venous blood clots, increased risk of heart attacks and strokes, worsening of undiagnosed prostate cancer and benign prostatic hyperplasia. Hemoglobin levels must be monitored and documented in the patient chart.

I certify that the patient (mark all that apply):

___has a documented low (<350 ng/dL) testosterone lab level at initiation of therapy or low level of free testosterone.

OR

___has a documented history of testosterone therapy but has discontinued therapy for 60 calendar days to re-evaluate levels and still has a documented low (<350 ng/dL) testosterone lab level;

AND/OR

___has primary hypogonadism, in which there is low testosterone accompanied by increased follicle-stimulated hormone and increased luteinizing hormone. Common causes include: Klinefelter's syndrome, anorchism, undescended testicles, mumps orchitis, hemochromatosis, injury to testicles, cancer treatment, and normal aging;

AND/OR

___has secondary hypogonadism, in which there is low testosterone accompanied by low to normal follicle-stimulated hormone and luteinizing hormone. Common causes include: Kallmann syndrome, pituitary disorders, inflammatory diseases, HIV/AIDS, medications, obesity, and stress-induced hypogonadism;

AND

___is physically symptomatic (e.g. malaise, fatigue, lethargy, muscle loss, depression, decreased bone mass or bone mineral density, etc.).

The following restriction is placed on the medications: Maximum dose is ***400 mg per month*** unless clinically indicated per labs. ***Labs (testosterone: total and free, CBC, PSA) must be submitted to the pharmacy with this letter, and if medication is continued, every 6 months thereafter.***

_____, M.D./D.O.

_____ Print M.D./D.O. name

_____ Florida medical license # (MEO #)

_____ Patient's 10 digit Medicaid # (if applicable)

_____ Patient's CIS # (assigned by the Ryan White Program Service Delivery Information System)

Please note: All questions should be addressed to Office of Management and Budget-Grants Coordination/Ryan White Program, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietician, etc.). Pursuant to the most current Professional Service Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client files (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

RYAN WHITE PROGRAM NUTRITIONAL ASSESSMENT LETTER FOR FOOD BANK SERVICES

[THIS LETTER IS REQUIRED FOR EXTENDED FOOD BANK SERVICES OVER AND ABOVE THE INITIAL TWENTY (20) OCCURRENCES (VISITS)]

(THIS DOCUMENT IS TO BE COMPLETED BY A LICENSED MEDICAL PROVIDER OR A REGISTERED DIETITIAN NOT ASSOCIATED WITH THE PART A FOOD BANK PROVIDER.)

DATE:_____

As the **licensed medical provider** for _____, it is my professional opinion that he/she requires an **extension** of food bank assistance.

OR

As a **registered dietitian** who has completed an assessment of _____, it is my professional opinion that he/she requires an **extension** of food bank assistance.

The client has the following **severe** change of status (mark all that apply):

__New HIV-related diagnosis/symptom (please describe) e.g. OI, AIDS diagnosis,etc._____

__Wasting syndrome

__Protein imbalance

__Recent chemotherapy

__Recent hospitalization

__Other medical reasons:_____

Please specify number of additional occurrences (maximum 16 additional occurrences within the current Ryan White Part A fiscal year): _____

This assistance will maintain the patient's health by providing a balanced, adequate diet, which the patient is currently not receiving.

Licensed Medical Provider Signature_____ Name_____

Print License #_____

OR

Registered Dietitian Signature_____ Name_____

Registered Dietitian License #_____

Please note: All questions should be directed to the Office of Management and Budget-Grants Coordination/Ryan White Program, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.). Pursuant to the most current Professional Service Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

Rev. 10/28/2016

RYAN WHITE PROGRAM
LETTER OF MEDICAL NECESSITY FOR
ANTIRETROVIRAL PHENOTYPE RESISTANCE ASSAYS FOR EXPERIENCED PATIENTS
COVERAGE IS LIMITED TO A MAXIMUM OF ONE PHENOTYPE IN ANY CONSECUTIVE 12-MONTH PERIOD.
(NOT REQUIRED FOR VIRTUAL PHENOTYPE TESTS)

Date:_____

As the primary medical caretaker for _____it is my considered opinion that he/she requires HIV phenotypic resistance testing. The following criteria have been met:

1. The patient at any time in the past has failed two (2) or more antiretroviral (ARV) regimens;

2. Results of at least one, preferably more, prior genotype(s) must be available in the chart and Resistance to two or more drugs per class in at least two classes of ARVs is present on prior genotype(s);

AND ONE OF THE FOLLOWING (check-off the appropriate condition below):

___Prior genotype(s) show(s) resistance to at least 2 PIs other than ritonavir and use of a PI is being considered;

OR

___Lopinavir/ritonavir is being considered in a PI-experienced patient with four or more mutations associated with resistance to lopinavir/ritonavir on a prior genotype;

OR

___Four or more mutations at codons associated with PI cross-resistance are present;

OR

___M184V mutation is present in the presence of 3 or more NRTI-associated mutations (NAMs);

OR

___K65R mutation is present, or other mutations associated with NRTI cross-resistance (69 insertion complex or 151 complex);

OR

___ Rescue ARV regimens guided by results of two or more prior genotypes have failed to suppress viral replication, whether mutations present or not, and the patient has been determined to be adherent on re-evaluation. (Requires a minimum of two prior genotypes.)

I understand HIV phenotypic resistance testing for experienced patients may only be ordered under the following conditions:

1. The above criteria have been met and are fully documented in the patient's medical record;
2. Adherence has been discussed with the patient on an on-going basis as part of his/her medical treatment, and it has been determined that the patient is fully adherent with his/her current ART regimen;
3. The patient's plasma HIV RNA (viral load) at the time of testing must be at least 1000 co/ml within the past month (attach copy to letter of medical necessity);
4. The patient must be on antiretroviral medications at the time of testing.

Sincerely,

_____, M.D.

Print Physician's name	Florida Medical License # (ME#)
Patient's 10 digit Medicaid # (if applicable)	Patient's CIS # (assigned by the Ryan White Program Service Delivery Information System)

Please note: All questions should be directed to the Office of Management and Budget-Grants Coordination/Ryan White Program, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.). Pursuant to the most current Professional Service Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

Rev. 3/1/2014

RYAN WHITE PROGRAM NUTRITIONAL SUPPLEMENTS REFERRAL
Physician Letter of Medical Necessity for Supplementation in ADULTS
(This form serves as a referral; the medical provider should maintain a copy of this form in the patient file.)

Date: _____

As the licensed medical provider for_____, who has a diagnosis of HIV/AIDS, it is my considered opinion that he/she requires and meets the criteria indicated below for nutritional supplements.

Patient must meet **at least two (2)** of the criteria listed below. (Dispensing limited to 4 bottles of any combination per month)

Please check all that apply:

____Current body weight < 10% IBW/UBW
____Body Mass Index (BMI) <20
____Recent illness/hospitalization that will interfere with patient's ability to consume or tolerate adequate non-supplemental nutrition
____Dysphagia and/or odonyphagia where commercial supplements are the only source of nutrition tolerated
____Inadequate living conditions or inability to buy/prepare meals
____Inability to understand and or follow nutritional recommendations
Weight loss of: ____5% of the initial/baseline weight over the past month -OR- ____7.5% over the past 3 months-OR- ____More than 10% within the last 6 months
____ Failure to gain/maintain weight in the past when following a dietary regimen to promote weight gain
____Body Cell Mass (BCM) < 40% (MALES) or BCM < 35% (FEMALE) of IBW
____Diarrhea/malabsorption with > 3 large, liquid stools/day
____Serum albumin < 3.5g/dl/Serum prealbumin (if available) <16mg/dl

I understand this patient's nutrition status must be evaluated by a Dietitian/Nutritionist no less than every 90 days.
Re-evaluation is due at _____. (*Number of refills authorized cannot exceed this period of time.*)
mm/dd/yy

I believe that nutritional supplements are medically indicated in this case and I have referred this patient for a professional Nutritional Assessment at _____.
Location

Sincerely,

_____ , M. D. / D.O. / ARNP / PA-C *(circle one)*
SIGNATURE
(Physician, Nurse Practitioner or Physician Assistant)

_____ _____
PRINT NAME Florida Medical License #
(Physician, Nurse Practitioner or Physician Assistant)

Please note: All questions should be directed to the Office of Management and Budget-Grants Coordination/Ryan White Program, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.). Pursuant to the most current Professional Service Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

RYAN WHITE PROGRAM NUTRITIONAL SUPPLEMENTS

(To be completed by the dietitian; the original of page 1 and a copy of page 2 must be maintained in the dietitian's patient file. A copy of page 1 and the original of page 2 should be forwarded to the pharmacy.)

Patient Name:_____ Date: _____

Please document patient:

Height:_____

ABW: _____ □ Lbs □ Kgs

IBW: _____ □ Lbs □ Kgs

UBW: _____ □ Lbs □ Kgs

Total Calories needed:_____g/kg/per day

Total Protein needed:_____g/kg/per day

Total Carbohydrates needed:_____g/kg/per day

Days Supply:_____

PRESCRIPTION

NOTE: 1 Serving = 2 Scoops

□ Ultra Meal Advance Protein Powder -___No. of **SERVINGS per DAY** (Only French Vanilla flavor available)
Number of Refills Authorized _____
(Number of refills authorized cannot exceed period of time for re-evaluation every 90 days by nutritionist/dietitian)

□ IgG Pure -____No. of **SERVINGS per DAY** (Only natural flavor available)
Number of Refills Authorized _____
(Number of refills authorized cannot exceed period of time for re-evaluation every 90 days by nutritionist/dietitian)

NUTRITIONAL PLAN FOR SUPPLEMENTS

I. INITIAL Consultation: Date: _____ Weight: _____

Patient assessed/instructed by Registered Dietitian/Nutritionist: **(Please check the appropriate box)**

☐ Nutritional supplements **recommended** ☐ Nutritional supplements **NOT** recommended

II. FOLLOW-UP Visit: Date:_____ Weight: _____

Patient re-assessed for progress: **(Please check the appropriate box)**

☐ Nutritional supplements **continued** ☐ Nutritional supplements **discontinued**

III. ADDITIONAL FOLLOW-UP Visit: Date: _____ Weight: _____

Patient re-assessed for progress: **(Please check the appropriate box)**

☐ Nutritional supplements **continued** ☐ Nutritional supplements **discontinued**

_____
SIGNATURE
(Registered Dietitian/Nutritionist)

_____ _____
PRINT NAME Dietitian/Nutritionist Florida License #
(Registered Dietitian/Nutritionist)

Please note: All questions should be directed to the Office of Management and Budget-Grants Coordination/Ryan White Program, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.). Pursuant to the most current Professional Service Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.