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United Healthcare Community Plan

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 (MM/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 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: _____

Providers who call 800-603-1714 or 877-553-7481 to verbally attest to an HIV diagnosis will be allowed a one-month override to allow time for diagnoses codes to be updated in the billing process or for this verification form to be submitted with medical records to Medicaid. Technology solutions have been implemented to allow claims to automatically process for maternal-fetal prophylaxis and assault victims.

Prescriber's Signature: _____Date: _____

Providers must retain copies of all documentation for five years.

Fax this form to 1-866-940-7328

Pharmacy PA Call Center:
1-800-310-6826

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