ND RYAN WHITE PROGRAM PART B REQUEST FOR TROGARZO™

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF DISEASE CONTROL
Rev. 11-18

Client's Name	ND Ryan White Client Number
Date Application Completed	

Instructions

- Medical provider must complete and sign this form including a description of why the client is in need of Trogarzo™.
- Fax the form to 701.328.0338.
- If all the conditions are met, approval in duration of 12 months will be granted per available ADAP funding.
- Medications reimbursed by ADAP are dispensed by local retail pharmacies.

Prescription Requested

Trogarzo™ (ibalizumab-uiyk) injection

To be completed by health care provider

Patient has met the following criteria:

- ☐ Inadequate response to 6 months of treatment with ART
- ☐ Viral load greater than 1,000 copies/mL
- ☐ Patient has multidrug resistant HIV-1 infection including documented resistance to at least one medication from each of the following classes as measured by resistance testing:
  - ☐ Protease Inhibitors (PI)
  - ☐ Nucleoside Reverse Transcriptase Inhibitors (NRTIs)
  - ☐ Non-nucleoside Reverse Transcriptase Inhibitors (NNRTIs)
- ☐ Patient is on an optimized background regimen for ART

Explanation for the prescription and the duration of the treatment:

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_____

_____

Signatures

_____ _____
Health Care Provider Date

_____ _____
Ryan White Part B Coordinator Date

ND Ryan White Program Part B Approval/Denial

☐ Approved ☐ Denied