**TEXAS HIV MEDICATION PROGRAM**
**MEDICAL CERTIFICATION FORM**

**(TO BE COMPLETED BY PHYSICIAN)** **Texas HIV Medication Code (if known)** _____

The information requested is necessary to determine the patient's eligibility for program-supplied, HIV-related therapy as prescribed by you. All information requested will be kept strictly confidential by the Texas Department of State Health Services. Personal identifying info is never released.

## PATIENT INFORMATION

Full Name: _____

Mailing Address: _____ Apt. # _____

City, State, Zip: _____ Phone # (____) _____

Date of Birth: ____/____/____ Social Security Number: _____
Month Day Year

*****NOTICE*** Changes in therapy after initial approval and/or recertification may be faxed to (512) 371-4670.**

I hereby certify that this patient has been diagnosed with HIV infection, and I am reporting the following viral load and CD4 count:

| Plasma RNA Viral Load: | Test Date: | Current CD4 Count: | Test Date: |
|---|---|---|---|
| _____ copies/ml | / / | | / / |

**PRESCRIBED MEDICATIONS FOR OPPORTUNISTIC INFECTIONS:**

_____ **Pentamidine** } For CD4 ≤ 200, or thrush, or
_____ **SMZ/TMP** } previous PCP diagnosis, or
_____ **Dapsone/TMP** } unexplained fever>100º for >2 weeks

***Please check here if patient is pregnant:*** _____

_____ **Acyclovir,** for acute or chronic herpetic infection
_____ **Itraconazole capsules** (Sporanox), for diagnosed histoplasmosis or blastomycosis
_____ **Clarithromycin** (Biaxin), for a current or previous mycobacterium avium complex (MAC) diagnosis, OR
_____ **Azithromycin** (Zithromax), if client failed therapy on, or is intolerant of, clarithromycin
_____ **Fluconazole**, for diagnosed cryptococcal meningitis or esophageal candidiasis, OR
_____ **Itraconazole suspension** (Sporanox), for diagnosed esophageal candidiasis
_____ **Ganciclovir** (Cytovene), for diagnosed CMV disease with infection(s) of major organ(s) or organ system(s), OR
_____ **Valganciclovir** (Valcyte), for diagnosed CMV disease with infection(s) of major organ(s) or organ system(s)
_____ **Megesterol Acetate** (Megace), for diagnosed cachexia or anorexia with profound, involuntary, acute weight loss ≥10% of baseline body weight or chronic weight loss ≥20% of baseline body weight
_____ **Atovaquone** (Mepron), for diagnosed acute, mild to moderate PCP and intolerance to both SMZ-TMP and dapsone
_____ **Rifabutin** (Mycobutin), for a CD4 cell count ≤ 100
_____ **Ethambutol** (Myambutol), for a current or previous mycobacterium avium complex (MAC) diagnosis

*****REQUIRED***** Is this patient naïve to antiretroviral therapy? (check one) _____ Yes _____ No

**PRESCRIBED ANTIRETROVIRAL MEDICATIONS: LIMIT OF FOUR (4) ANTIRETROVIRALS MAX PER CLIENT**

_____ **zidovudine** (AZT, Retrovir)
_____ **didanosine** (DDI, Videx)
_____ **zalcitabine** (DDC, Hivid)
_____ **stavudine** (D4T, Zerit)
_____ **lamivudine** (3TC, Epivir)
_____ **abacavir sulfate** (Ziagen)
_____ **Combivir** (AZT/3TC)*
_____ **Trizivir** (AZT/3TC/Ziagen)*
_____ **emtricitabine** (Emtriva)
_____ **Truvada** (Emtriva/Viread)*
_____ **Epzicom** (3TC/Ziagen)*

_____ **invirase** (Saquinavir)
_____ **ritonavir** (Norvir)
_____ **indinavir** (Crixivan)
_____ **nelfinavir** (Viracept)
_____ **amprenavir** (Agenerase)
_____ **lopinavir/ritonavir** (Kaletra)
_____ **atazanavir** (Reyataz)
_____ **fosamprenavir** (Lexiva) – boosted dosage, 1bottle/mo (recommended)
_____ **fosamprenavir** (Lexiva) – unboosted dosage (2 bottles/mo without low-dose ritonavir); requires consultation with THMP Physician.

_____ **nevirapine** (Viramune)
_____ **delavirdine** (Rescriptor)
_____ **efavirenz** (Sustiva)
_____ **tenofovir** (Viread)
_____ **tipranavir** (Aptivus)
_____ **darunavir** (Prezista)
_____ **Atripla** (Sustiva/Truvada)*

**Please note:** *For the 4 antiretroviral limit, Combivir, Truvada & Epzicom each count as 2 antiretrovirals; Trizivir & Atripla count as 3 antiretrovirals.

PHYSICIAN SIGNATURE: _____ TX MD/DO LICENSE #: _____

PRINTED NAME OF PHYSICIAN: _____

OFFICE ADDRESS: _____

TELEPHONE: _____ FAX: _____ DATE ____/____/____