Certificate of Medical Necessity
Ibalizumab-uiyk (Trogarzo™) for HIV-1

Patient Name: ____ **Site:** ______________________

SECTION A

Diagnosis:

☐ **B20** Human immunodeficiency virus (HIV) disease

1. Dosage Ordered: ☐ Initial: 2,000 mg IV x 1 dose
   ☐ Maintenance: 800 mg IV every 2 weeks
2. Has the patient received this treatment at another facility? ☐ Yes ☐ No
3. If **YES to #2**, is this a re-initiation of therapy (>14 days since last dose)? ☐ Yes ☐ No
   a. Last Treatment Date: b. Date of 1st Treatment:
   c. Facility Name:

SECTION B

Clinical Documentation

4. Is the patient 18 years of age or older? ☐ Yes ☐ No
5. Physician documentation clearly indicates diagnosis of HIV-1 infection. ☐ Yes ☐ No
6. Documentation of relevant baseline labs and tests: ☐ Yes ☐ No
   a. CD4+ count: _________ b. Viral load: _________
7. Will Trogarzo™ be given in combination with an antiretroviral regimen containing at least one antiretroviral agent demonstrating full viral susceptibility? ☐ Yes ☐ No
   List ARTs to be given in combination with Trogarzo™:
8. Does the patient have multi-drug resistant HIV-1? ☐ Yes ☐ No
9. If **YES to #7**, provide additional information below on all previous failed therapies attempted.

Antiretroviral Therapy	Response	Dates of Treatment

10. a. Name of Referring Physician: ☐ N/A
    b. Initial Office Visit with OIC Physician Scheduled? ☐ Yes ☐ No
    c. If **YES**, visit date (if known) :

Form Completed by: Total # of Pages: **Date:**

Trogarzo™ is medically necessary for the treatment of multi-drug resistant HIV-1 infection in this adult patient who has failed multiple antiretroviral regimens.

Physician Signature: **Date:**