

**TEXAS HIV MEDICATION PROGRAM  
MEDICAL CERTIFICATION FORM  
Fax to (512) 989-4003**

**(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.

\*\*\* Both pages are required. \*\*\*

**PATIENT INFORMATION**

Full Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Apt. # \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Month Day Year

**Requested Pharmacy:** \_\_\_\_\_

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

<b>Plasma RNA Viral Load:</b>  copies/ml	<b>Test Date:</b>  / /	<b>Current CD4 Count:</b>  / /	<b>Test Date:</b>  / /
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**\*REQUIRED\*** Is this patient new to any medications in this antiretroviral therapy regimen?  
(check one) Yes ☐ No ☐

On the following page, mark the appropriate box to specify supply quantity for each medication prescribed. Medications marked n/a indicate the medication is not eligible for a 90-day supply. **Please refer to the [THMP Medication Formulary and Maximum Quantities Table](#) for available dosages and quantities of medications.**

Providers should reserve prescribing a 90-day medication supply for people on stable medication regimens; medications that are new or have changed in dose for a patient are not eligible to be dispensed as 90-day supply.

**\*Note:** Combivir, Descovy, Dovato, Evotaz, Epzicom, Prezcoibx, Truvada, & Juluca each count as 2 ARVs; Atripla, Complera, Odefsey, Trizivir, Triumeq, Biktarvy, & Delstrigo each count as 3 ARVs; Stribild, Symtuza, and Genvoya each count as 4 ARVs. **HLA-B\*5701 test result of negative is required for treatment-naïve patients starting medications that contain abacavir (Ziagen, Epzicom, Trizivir, or Triumeq).**

*I certify that this patient is being prescribed the medications selected on the attached page.*

PHYSICIAN SIGNATURE: \_\_\_\_\_ TX MD/DO LICENSE #: \_\_\_\_\_

PRINTED NAME OF PHYSICIAN: \_\_\_\_\_

OFFICE ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

**\*\*\*NOTICE\*\*\*** Changes in therapy after initial approval and/or recertification may be faxed to (512) 989-4003.

If this form is completed as part of an initial program application, it should be mailed to:  
Texas HIV Medication Program, ATTN: MSJA - MC1873, PO Box 149347, Austin, TX 78714-9347

Patient Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Texas HIV Medication Code (if known): \_\_\_\_\_

Qty Prescribed (days)		Qty Prescribed (days)		Qty Prescribed (days)	
<b>30 day</b>		<b>30 day</b>		<b>30 day</b>	
<input type="checkbox"/> azithromycin	OR	<input type="checkbox"/> Clarithromycin			(choose one)
<input type="checkbox"/> Dapsone	OR	<input type="checkbox"/> pentamidine	OR	<input type="checkbox"/> SMZ/TMP	(choose one)
<input type="checkbox"/> acyclovir	OR	<input type="checkbox"/> famciclovir	OR	<input type="checkbox"/> Valacyclovir	(choose one)
<input type="checkbox"/> Gynazole (butoconazole)	OR	<input type="checkbox"/> Monistat (tioconazole)	OR	<input type="checkbox"/> terconazole topical	(choose one)
<input type="checkbox"/> fluconazole	OR	<input type="checkbox"/> itraconazole	OR	<input type="checkbox"/> Voriconazole	(choose one)
<input type="checkbox"/> atovaquone (Mepron)				<input type="checkbox"/> clindamycin	
<input type="checkbox"/> ethambutol				<input type="checkbox"/> clotrimazole troche	
<input type="checkbox"/> leucovorin calcium tablets				<input type="checkbox"/> isoniazid	
<input type="checkbox"/> megestrol acetate oral susp				<input type="checkbox"/> nystatin oral susp	
<input type="checkbox"/> Daraprim (pyrimethamine)				<input type="checkbox"/> Oravig (miconazole)	
<input type="checkbox"/> rifabutin				<input type="checkbox"/> prednisone	
<input type="checkbox"/> Valcyte (valganciclovir)				<input type="checkbox"/> primaquine phosphate	
<input type="checkbox"/> Egrifta (tesamorelin acetate P/F)				<input type="checkbox"/> rifampin	
<input type="checkbox"/> Mytesi (crofelemer)				<input type="checkbox"/> sulfadiazine	
<input type="checkbox"/> Baraclude		<input type="checkbox"/> Vemlidy			
<b>90 day</b>		<b>90 day</b>		<b>90 day</b>	
<input type="checkbox"/> Amlodipine (5mg/#90)		<input type="checkbox"/> Atorvastatin (20mg/#90)		<input type="checkbox"/> Duloxetine (30mg/#90)	
<input type="checkbox"/> Gabapentin (300mg/#100)		<input type="checkbox"/> Hydrochlorothiazide (25mg/#100)		<input type="checkbox"/> Lisinopril (10mg/#100)	
<input type="checkbox"/> Livalo (2mg/#90)		<input type="checkbox"/> Metformin (500mg/#100)		<input type="checkbox"/> Metoprolol Tart (50mg/#100)	
<input type="checkbox"/> Sertraline (50mg/#30)		<input type="checkbox"/> Trazodone (100mg/#100)		<input type="checkbox"/> Zypitamag (2mg/#90)	
<b>ANTIRETROVIRALS RX: MONTHLY CLIENT LIMIT OF FOUR ANTIRETROVIRALS (ARVs)</b>					
<b>30 day</b>		<b>30 day</b>		<b>30 day</b>	
<input type="checkbox"/> Aptivus (TPV)		<input type="checkbox"/> Atripla (ABC/FTC/TDF)		<input type="checkbox"/> Biktarvy (BIC/FTC/TAF)	
<input type="checkbox"/> Combivir (AZT/3TC)		<input type="checkbox"/> Complera (FTC/RPV/TDF)		<input type="checkbox"/> Delstrigo (DOR/3TC/TDF)	
<input type="checkbox"/> Descovy (FTC/TAF)		<input type="checkbox"/> Dovato (DTG/3TC)		<input type="checkbox"/> Edurant (RPV)	
<input type="checkbox"/> Emtriva (FTC)		<input type="checkbox"/> Epivir (3TC)		<input type="checkbox"/> Epzicom (ABC/3TC)	
<input type="checkbox"/> Evotaz (ATV/c)		<input type="checkbox"/> Genvoya (c/EVG/FTC/TAF)		<input type="checkbox"/> Intelence (ETR)	
<input type="checkbox"/> Invirase (SQV)		<input type="checkbox"/> Isentress (RAL)		<input type="checkbox"/> Isentress HD (RAL)	
<input type="checkbox"/> Juluca (DTG/RPV)		<input type="checkbox"/> Kaletra (LPV/r)		<input type="checkbox"/> Lamivudine/Tenofovir (3TC/TDF)	
<input type="checkbox"/> Lexiva (FPV)		<input type="checkbox"/> Norvir (ritonavir)		<input type="checkbox"/> Odefsey (RPV/FTC/TAF)	
<input type="checkbox"/> Pifeltro (DOR)		<input type="checkbox"/> Prezcoibix (DRV/c)		<input type="checkbox"/> Prezista (DRV)	
<input type="checkbox"/> Reyataz (ATV)		<input type="checkbox"/> Rukobia ER (fostemsavir)		<input type="checkbox"/> Selzentry (MVC)	
<input type="checkbox"/> Stribild (c/EVG/FTC/TDF)		<input type="checkbox"/> Sustiva (EFV)		<input type="checkbox"/> Symfi (EFV/3TC/TDF)	
<input type="checkbox"/> Symtuza (c/DRV/FTC/TAF)		<input type="checkbox"/> Tivicay (DTG)		<input type="checkbox"/> Triumeq (DTG/ABC3TC)	
<input type="checkbox"/> Trizivir (AZT/ABC/3TC)		<input type="checkbox"/> Truvada (FTC/TDF)		<input type="checkbox"/> Viracept (NFV)	
<input type="checkbox"/> Viramune XR (NVP)		<input type="checkbox"/> Viread (TDF)		<input type="checkbox"/> Ziagen (ABC)	
<input type="checkbox"/> Zidovudine (AZT)					