

Antivirals: HIV -

Descovy® (emtricitabine / tenofovir alafenamide) - Washington Prior Authorization Request Form

Please complete this <u>entire</u> form and fax it to: 866-940-7328. If you have questions, please call 800-310-6826.

This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.

Allow at least 24 hours for review

Last Name: Last Name: Member ID:	Section A – Member Inforn		iow at least 24 flou	rs for review.		
City: State: ZIP Code: Phone: DOB: Allergies: Primary Insurance Information (if any): Is the requested medication: New or Continuation of Therapy? If continuation, list start date: Is this patient currently hospitalized? Yes No If recently discharged, list discharge date: Section B - Provider Information First Name: Last Name: M.D./D.O. Address: City: State: ZIP code: Phone: Fax: NPI #: Specialty: Office Contact Name / Fax attention to: Section C - Medical Information Medication: Strength: Diagnosis (Please be specific & provide as much information as possible): ICD-10 CODE: Is this member pregnant? Yes No If yes, what is this member's due date? Medication Name Strength Directions Dates of Therapy Reason for failure / discontinuation			Last Name:	I	Member ID:	
Phone: DOB: Allergies:	Address:			<u>'</u>		
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First Name: Address: City: State: ZIP code: Phone: Phone: Fax: NPI #: Specialty: Office Contact Name / Fax attention to: Section C - Medical Information Medication: Strength: Directions for use: Quantity: Diagnosis (Please be specific & provide as much information as possible): Is this member pregnant? Yes No If yes, what is this member's due date? Section D - Previous Medication Trials Medication Name Strength Directions Dates of Therapy Reason for failure / discontinuation	Is this patient currently he	ospitalized? 🗆	Yes □ No If recently	discharged, list discha	arge date:	
Address: City: State: ZIP code:	Section B - Provider Inforr	mation				
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Medication: Directions for use: Quantity: Diagnosis (Please be specific & provide as much information as possible): Is this member pregnant? Yes No	Office Contact Name / Fax atte	ention to:		1		
Directions for use: Diagnosis (Please be specific & provide as much information as possible): Is this member pregnant?		nation			0, 4	
Diagnosis (Please be specific & provide as much information as possible): Is this member pregnant? □ Yes □ No	Medication:				Strength	1:
Is this member pregnant? □ Yes □ No	Directions for use:					<i>y</i> :
Section D – Previous Medication Trials Medication Name Strength Directions Dates of Therapy Reason for failure / discontinuation	Diagnosis (Please be specific	& provide as much	information as possible)	:	ICD-10 C	CODE:
Medication Name Strength Directions Dates of Therapy Reason for failure / discontinuation	Is this member pregnant?	Yes □ No	If yes, what is this	member's due date?		
Medication Name Strength Directions Dates of Therapy discontinuation	Section D – Previous Medi	ication Trials				
	Medication Name	Strength	Directions	Dates of Therapy		
Section E – Additional information and Explanation of why preferred medications would not meet the patient's need	Section E – Additional info	ormation and Ex	planation of why pref	erred medications wou	ld not meet th	ne patient's needs
		•	·	•		
Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives						



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lember	First name:	Member Last name:	Member [DOB:				
		Clinical and Drug Specif	ic Information					
 Has patient used this medication within the last 6 months? Yes No If yes, contact patient's pharmacy. The pharmacy may submit the claim with Expedited Authorization (EA): 85000000006: Continuation of pre-exposure prophylaxis (PrEP) therapy. 85000000007: Continuation of antiviral treatment. 								
2.	What is this request prescribed HIV-1 Treatment. Which oth	for? er ART medication will be used	d in combination with	emtricitabine/TAF?				
	PrEP. Provide date of last ne	gative test for HIV-1:						
	Other:	_						
3.	What is the patient's current we	ight? kg Dat	e taken:					
4.	What is the patient's creatinine	clearance? mL/n	nin Date taken:					
5.	Arm or hip fracture v Vertebral compressi T-score ≤ -2.0 (DXA) Taking glucocorticos • What is • What is	history of kidney disease ons as determined by a history with minimal trauma	months orticoid regimen? d regimen?					
D		and LAB TESTS ARE REQU	IRED FOR THIS REQ					
Prescrib	per signature	Prescriber specialty		Date				

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