

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

Please complete this **entire** 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.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		
Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> 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:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> 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

**Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:
Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives**

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Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

1. 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 for?
 - HIV-1 Treatment. Which other ART medication will be used in combination with emtricitabine/TAF? _____

 - PrEP. Provide date of last negative test for HIV-1: _____

 - Other: _____

3. What is the patient’s current weight? _____ kg Date taken: _____

4. What is the patient’s creatinine clearance? _____ mL/min Date taken: _____

5. Check all that apply for patient:
 - Requires renal hemodialysis
 - Hypertension
 - Diabetes
 - Hepatitis C
 - CrCl has decreased ≥ 25% from baseline
 - African American with family history of kidney disease
 - High risk for bone complications as determined by a history of:
 - Arm or hip fracture with minimal trauma
 - Vertebral compression factor
 - T-score ≤ -2.0 (DXA) at the femoral neck or spine
 - Taking glucocorticosteroids for more than two (2) months
 - What is the diagnosis requiring glucocorticoid regimen? _____
 - What is patient’s current glucocorticoid regimen? _____
 - What is the expected duration of therapy of glucocorticoid regimen? _____

CHART NOTES and LAB TESTS ARE REQUIRED FOR THIS REQUEST

Prescriber signature	Prescriber specialty	Date
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