UnitedHealthcare Community Plan

Antivirals : HIV – 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: □ 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:**
Directions for use:	**Quantity:**
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? _____

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

UnitedHealthcare Community Plan

Antivirals : HIV – Descovy® (emtricitabine / tenofovir alafenamide) - Washington
Prior Authorization Request Form

Member First name:	Member Last name:	Member DOB:

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 glucocorticosteriods 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