coordinated care

Antivirals: HIV– emtricitabine / tenofovir alafenamide (Descovy®)

Please fax this completed form to (833) 645-2734 OR mail to: Pharmacy Services| 5 River Park Place East, Suite 210 | Fresno, CA 93720. You can also complete online at CoverMyMeds.com.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

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

Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)