HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
DESCOVY®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Descovy® (emtricitabine and tenofovir alafenamide)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Does the member have documentation of renal dysfunction (creatinine clearance ≤ 50 mL/min)?	☐	☐	**Please provide documentation**
2. Does the member have documentation of tenofovir disoproxil fumarate induced renal dysfunction?	☐	☐	**Please provide documentation**
3. Did the member have a new onset or worsening of renal dysfunction after starting a tenofovir disoproxil fumarate regimen?	☐	☐	**Please provide documentation**
4. Does the member have a documented concurrent therapy with a drug that is considered medically necessary and likely to cause or exacerbate renal dysfunction?	☐	☐	**Please provide documentation**
5. Does the member have an intolerance or contraindication to emtricitabine and tenofovir disoproxil fumarate (generic Truvada®)?	☐	☐	**Please provide documentation**
6. For treatment of HIV infection, will Descovy® be used as part of an antiretroviral treatment (ART) regimen?	☐	☐	
7. For PrEP, is the request for an at-risk adult or adolescent (≥ 35 kg) to reduce the risk of sexually acquired HIV-1 infection?	☐	☐	
8. For PrEP, is the member confirmed to be HIV-negative within 30 days prior to initiation of therapy?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	

2. Has the therapy shown to the tolerable and effective?	☐	☐	**Please provide documentation**
3. Does updated documentation show a continued medical need for therapy?	☐	☐	**Please provide documentation**
4. For PrEP, does the member have documented negative HIV-1 tests every 3 months?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician Signature:

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Policy PHARM- 111
Origination Date: 10/29/2020
Reviewed/Revised Date: 11/23/2020
Next Review Date: 11/23/2021
Current Effective Date: 01/01/2021