Descovy Prior Authorization Form

Instructions:

- Fax completed form and documentation to ADAP confidential fax line at 850-412-2680.
- For any questions regarding this form, please contact the HIV Medical Team at HIVMedicalTeam@flhealth.gov.

Note: Prescriber will receive a written response via fax within three business days.

PATIENT LAST NAME:	**PATIENT FIRST NAME:**	**DATE OF BIRTH:** / /
PRESCRIBER NAME (first and last):		
CREDENTIALS: ☐ **APRN**	☐ **DO** ☐ **MD**	☐ **PA**
PRESCRIBER LICENSE NUMBER:		
PRESCRIBER PHONE:	**PRESCRIBER FAX:**	
PRESCRIBER EMAIL:		
OFFICE CONTACT NAME /NUMBER:		

COVERAGE FOR INSURED CLIENTS ONLY *Select one of the options below.*	
☐	Patient's insurance will be the primary payor and ADAP will cover copay only • Submission of this form is not required. • **You will be contacted to provide information, if needed, before *a coverage determination is made.***
☐	Patient's insurance has denied coverage and ADAP will be the sole payor • Submit documentation of insurance denial for Descovy • **Complete remainder of this form and submit completed form and documentation as instructed above.**

- **Important Notes:**
  - Florida ADAP may need to implement a patient cap
  - If request is for continuation of therapy, complete patient and provider information on the top of the form and proceed to page 3
  - Descovy approval will be provided for a maximum of 1 year
  - Provider is responsible for the care and assessment of the patient

Descovy (emtricitabine / tenofovir alafenamide) Prior Authorization Form
Florida AIDS Drug Assistance Program

DESCOVY CRITERIA FOR USE

- **Patient must meet all criteria listed below to receive Descovy through Florida ADAP.**
- **If the patient does not meet one or more of these criteria, please submit a written explanation for the rationale for requesting Descovyfor your patient. These requests will be considered on a case-by-case basis.**

Select all that apply:

☐	Individual with HIV-1 infection in combination with other ART medications
☐	Individual does not have any contraindications or resistance mutations to component of Descovy
☐	CrCl is calculated to be <60 mL/min
☐	Patient is not on any concomitant medications that are contraindicated or not recommended for use with Descovy

NRTI = nucleoside reverse transcriptase inhibitor, NNRTI = non-nucleoside reverse transcriptase inhibitors, PI = protease inhibitor, INSTI = integrase strand transfer inhibitor

Authorizations will be approved for 12 months, providing patient remains virally suppressed. For requests for continuation of therapy, provide the following information:

- Start date of Descovy: _____
  - If patient was getting Descovy coverage through another source besides Florida ADAP, please indicate, how patient was getting (e.g., private insurance, Medicaid, etc.):

- Other antiretrovirals the patient is taking with Descovy:

☐ **I understand that ADAP may rescind the approval for Descovy (with prior provider notice) for any reason [e.g., patient is not responding adequately (e.g., rising viral load while on therapy), patient is not adherent, fiscal constraints].**

PRESCRIBER SIGNATURE:		**Date:**	**/ /**
ADAP USE ONLY			
CLIENT ID NUMBER:		**Date Request Received:**	**/ /**
Request Approved:	☐ Yes ☐ No	**Reviewed by:**	