coordinated care

envolve Pharmacy Solutions

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

Please fax this completed form to (866) 399-0929 OR mail to: Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

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. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
   If yes, for diagnosis of HIV-1, has patient's condition worsened?
   ☐ Yes. Specify reason: ☐ Viral load < 200 copies/mL ☐ Increasing CD4 cell count
   ☐ No

2. What is this request prescribed for?
   ☐ HIV-1
   ☐ Pre-exposure prophylaxis (PrEP) in adults and adolescents at risk of HIV-1 infection from sexual acquisition, excluding individuals at risk from receptive vaginal sex
   Has patient tested negative for HIV-1? ☐ Yes. Date tested: ☐ No
   ☐ Other. Specify:

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

4. Will emtricitabine - tenofovir alafenamide be used for HIV-1 in combination with other appropriate antiretroviral agents?
   ☐ Yes, specify:
   ☐ No

5. What is the patient's creatinine clearance? mL/min Date taken:

6. Check all that apply for patient:
   ☐ Requires renal hemodialysis
   ☐ Diabetes
   ☐ Hepatitis C
   ☐ 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
   - ☐ Chronic kidney with proteinuria, low phosphate or is grade 3 or worse
   - ☐ T-score ≤ -2.0 (DXA) at the femoral neck or spine
   - ☐ Glucocorticoid-therapy 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 ARE REQUIRED WITH THIS REQUEST		
Prescriber signature	Prescriber specialty	Date

Envolve Pharmacy Solutions 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.)