MOLINA HEALTHCARE

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

Please provide the information below, print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request.
**Please FAX responses to: (800) 869-7791. Phone: (800) 213-5525, Option 1-2-2.**

| | | | |
|---|---|---|---|
| Date of request | | | |
| Patient | Date of birth | Molina ID | |
| Pharmacy name | Pharmacy NPI | Telephone number | Fax number |
| Prescriber | Prescriber NPI | Telephone number | Fax number |
| Medication and strength | | | Qty/Days supply |
| Directions for use | | | |

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 |
|---|---|---|
| | | |