PRIOR AUTHORIZATION REQUEST

DESCOVY

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Does the patient weigh 35 kilograms or greater? [If no, no further questions.]	Yes	No
2	What is the patient's indication of use for the requested medication? [] Human immunodeficiency virus (HIV-1) treatment (If checked, go to 3) [] Pre-exposure prophylaxis (PrEP) treatment (If checked, go to 3)		

If you have any questions, call: 1-888-258-8250

Version 01.2026

PRIOR AUTHORIZATION REQUEST

	[] Other (If checked, no further questions)		
3	Is this a request for initial or continuation of treatment? [] Initial (If checked, go to 5) [] Continuation (If checked, go to 4)		
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [If yes, skip to question 8.]	Yes	No
5	Does the patient have a contraindication to emtricitabine/tenofovir (Truvada)? [If yes, no further questions.]	Yes	No
6	Has documentation been provided to confirm that the patient has experienced intolerance, adverse side effect, or treatment failure to the generic formulation emtricitabine/tenofovir (Truvada)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
7	Has a MedWatch Form 3500 been completed and submitted with this request? ACTION REQUIRED: Submit supporting documentation. [Note: The MedWatch form can be obtained from http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM163919.pdf. Provider must attach the MedWatch Form as proof of submission.] [No further questions.]	Yes	No
8	Has the patient been evaluated to confirm treatment response? ACTION REQUIRED: Submit supporting documentation.	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

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Version 01.2026

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FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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Version 01.2026