

--SAMPLE--

This letter is only intended as a TEMPLATE Letter of Medical Necessity for DESCOVY FOR PrEP® (pre-exposure prophylaxis)
INSTRUCTIONS: MUST BE ON HEALTHCARE PROVIDER'S LETTERHEAD AND MUST BE COMPLETED AND SUBMITTED BY THE HEALTHCARE PROVIDER. Please see the full prescribing information, including Boxed Warning at www.descovy.com/hcp.

[Healthcare Provider's Stationery] [Insert Date]

[Medical Director] [Insurance Company] [Address]
[City, State ZIP]

RE: Prior Authorization for DESCOVY FOR PrEP® (pre-exposure prophylaxis) Use
Patient Name: [Insert Patient Name]
Policy Number: [Insert Policy Number]
Claim Number: [Insert Claim Number]
Subject: Prior Authorization of DESCOVY FOR PrEP

Dear [Insert Medical Director's Name]:

On behalf of my patient, [patient name], I am writing this letter to document the medical necessity of DESCOVY FOR PrEP® (emtricitabine 200mg / tenofovir alafenamide 25mg tablets) (pre-exposure prophylaxis).

This letter serves to document my patient's condition and medical history, summarize my prescribing decision rationale, and provide a copy of the Prescribing Information for DESCOVY FOR PrEP.

[Name of patient] is a [age]-year-old [patient] who was initially considered to be an appropriate candidate for HIV PrEP medication on [mm-dd-yyyy] by [Healthcare Provider] at [Facility]. [Name of patient] has been in [healthcare provider's name] care since [date].

[Provide a brief discussion of patient's history and current condition, laboratory results, and previous treatments if applicable, highlighting those factors leading you to recommend the use of DESCOVY FOR PrEP].

DESCOVY FOR PrEP [was/will be] prescribed for [patient name] for pre-exposure prophylaxis.

[Conclusion statement regarding whether DESCOVY FOR PrEP is appropriate and reasonable for the patient.] Please contact me at [healthcare provider's telephone number] if you have any questions or if any additional information is required to ensure the prompt approval of this course of treatment.

Please see the Full Prescribing information for DESCOVY at www.descovy.com/hcp.

Sincerely,
[Healthcare Provider's Signature]

[Healthcare Provider Name] [Provider Identification Number]
[phone number]

[Enclosures: List enclosures, which may include: DESCOVY FOR PrEP Prescribing Information, clinical notes, and any other relevant supporting documentation]

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