Prescription Medication Prior Authorization Request Form

☐ Standard PA Request ☐ Urgent/Expedited PA Request

Please fill out all sections and attach any important documentation such as chart notes or lab results to support the PA request.
Once completed, submit to WithMe Health via fax at **1-866-678-8301**

Patient Information

Patient Name (Last, First, MI):		
Member ID Number:	Date of Birth:	Patient Phone Number:
Patient Address:		
Patient's Authorized Representative (If applicable):		Authorized Rep Phone Number:

Provider Information

Requesting Provider's Name:		
NPI:	Specialty:	
Office Address:		
Office Phone:	Office Fax:	
Office Contact Name:	Phone:	Fax:
Dispensing Pharmacy Name/Place of Service:	Phone:	Fax:

Requested Medication Information

Medication Name and Strength:	
Dose and Frequency (Sig):	
Qty Per 30 Days:	Expected Duration of Therapy:
ICD-10(s):	Diagnosis:

Please check one of the boxes below. If established, please include therapy start date:

☐ New Therapy ☐ Samples ☐ Clinical Trial ☐ Established Date Therapy Started: _____

Previous Therapies Used for Diagnosis (Rx and OTC products)

Medication Name, Strength, Dose, Frequency	Dates Used	Outcome of Therapy (e.g., Ineffective, Not Tolerated)

Medical Rationale for Use of Requested Medication (**Please attach chart notes, lab work etc. when submitting this request. If applicable, please include why formulary therapies may be contraindicated for this patient.** Please also include which therapies will be used along with the requested medication. If patient is established on the requested medication, please include recent documentation of how the patient has responded to therapy.):

Disease State Specific Questions

Please provide the following information:

1. Provide baseline documentation for the following:
   a. Serum creatine and/or creatine clearance _____
   b. Bone mineral density _____
   c. Patient's weight _____
2. Is the patient being treated for HIV? ☐ Yes ☐ No
   a. If yes, was diagnosis confirmed with an HIV antibody test? ☐ Yes ☐ No
   b. If yes, will be drug be used in combination with another antiretroviral? ☐ Yes ☐ No
3. Is the patient being treated for Preexposure prophylaxis of HIV-1 infection
   a. Is there confirmation of negative HIV status within the previous 14 days of request ☐ Yes ☐ No
   b. Please indicate which of the following apply:
      i. ☐Confirmation of Men Who Have Sex with Men (MSM) Risk Index Score of 10 or greater (See Appendix 4)
      ii. ☐Patient is an injection drug user (IDU) and both of the following:
      iii. ☐Patient has used injection drugs not prescribed by a clinician in the past 6 months
      iv. ☐Has shared injection or drug preparation equipment in the past 6 month
   c. Will the medication be used as monotherapy and will not be administered with any other antiretroviral treatment? ☐ Yes ☐ No
4. Is the patient being treated for nonoccupational postexposure prophylaxis (nPEP)? ☐ Yes ☐ No
   a. If yes, which of the following apply?
   ☐There is confirmation of negative HIV status
   ☐It has been ≤72 hours since exposure
   ☐Truvada (emtricitabine/tenofovir disoproxil fumarate) is being used in combination with an appropriate antiretroviral treatment
   ☐Descovy is being used for nPEP
5. Is the patient being treated for Occupational postexposure prophylaxis (oPEP)? ☐ Yes ☐ No
   a. If yes, which of the following apply?
   ☐There is confirmation of negative HIV status
   ☐It has been ≤72 hours since exposure
   ☐Truvada (emtricitabine/tenofovir disoproxil fumarate) is being used in combination with an appropriate antiretroviral treatment
   ☐Descovy is being used for oPEP
6. Is the patient being treated for HIV-1 and Hepatitis B co-infection? ☐ Yes ☐ No
   a. If yes, was the diagnosis of HIV-1 - confirmed with a positive HIV antibody test? ☐ Yes ☐ No
   b. If yes, was the diagnosis of Hepatitis B confirmed with a positive hepatitis B surface antigen (HBsAG) or hepatitis b surface antibody (anti-HBs) and/or IgG hepatitis B core antibody (anti-HBc)? ☐ Yes ☐ No

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by WithMe Health, the health plan sponsor, or, if applicable, a state or federal regulatory agency.

_____ _____

Provider Signature Date