BlueCross BlueShield Federal Employee Program.

ACA HIV Prevention Coverage Member Request Form

Send completed form to:
Service Benefit Plan
Attn: Reconsideration
P.O. Box 52080
Phoenix, AZ 85072-2080
FAX: 1-877-378-4727

CARDHOLDER COMPLETES

Date: ____ / ____ / _____

Patient Name: _____ / _____ / _____
First MI Last

Patient Address: _____
Street Address

_____
City / State / Zip

Patient Date of Birth: ____ / ____ / ____ Sex: M ☐ F ☐ R ☐☐☐☐☐☐☐☐☐

If approved, your $0 prevention benefit override will be applied for the benefit year. Approval reauthorization is required for <u>each benefit year</u>.

PHYSICIAN COMPLETES

_____ _____ _____
Physician Name (Print Clearly) Specialty Physician NPI #

Physician Address: _____
Street Address

_____ (_____)_____ (_____)_____
City / State / Zip Office Phone Office Fax

NOTE: Drug selection and prescribing physician signature <u>must be completed</u> to process this request:

Please select drug requested:

1. ❑ Emtricitabine-Tenofovir Disoproxil Fumarate 200-300MG (Generic Truvada)

I attest, as prescribing physician, to ALL of the following:

i. This member is at high risk for contracting HIV
ii. The requested medication is being used for **prevention of HIV (HIV PrEP) <u>only</u>**
iii. The requested medication is **not** being used for treatment of HIV

2. ❑ Descovy

I attest, as prescribing physician, to ALL of the following:

i. This member is at high risk for contracting HIV
ii. The requested medication is being used for **prevention of HIV (HIV PrEP) <u>only</u>**
iii. The requested medication is **not** being used for treatment of HIV
iv. This member has had a **therapeutic failure(s) or adverse event(s) to Truvada**

_____ ____/____/____
Physician Signature Date

Prescriber Certification: I certify that I am the physician and all information provided on this form to be true and correct to the best of my knowledge and belief.
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