Effective Date: 9/15/2020
Reviewed: 6/2020, 4/2021, 3/2022, 3/2023 Scope: Medicaid

Descovy

POLICY

I. CRITERIA FOR APPROVAL

An authorization may be granted when all the following criteria are met:

A. The patient has tried and failed emtricitabine/tenofovir disoproxil fumarate therapy due to one of the following:
   a. The member experienced side effects while utilizing emtricitabine/tenofovir disoproxil fumarate (i.e., decreased bone mineral density or renal toxicity); OR
   b. The member has a contraindication or intolerance to emtricitabine/tenofovir disoproxil fumarate

II. QUANTITY LIMIT

- 30 tablets per 30 days

III. COVERAGE DURATION

- 12 months

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