# OPTIMA HEALTH FAMILY CARE

## (MEDICAID)

### MEDICAL/PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

**Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request.** All other information may be filled in by office staff; **fax to 1-844-723-2094.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is NOT complete, correct, or legible, authorization can be delayed.**

**DRUG REQUESTED: Trogarzo®** (ibalizumab-uiyk) **IV (J1746) (Medical)**

**DRUG INFORMATION:** Complete **all** information below or authorization will be delayed.

**Drug Form/Strength:** _____

**Dosing Schedule**: _____ **Length of Therapy**: _____

**Diagnosis:** _____ **ICD Code, if applicable:** _____

***MEDICATION WILL BE PROVIDED BY THE PHYSICIAN'S OFFICE***

**CLINICAL CRITERIA:** Check below **ALL** that apply. **ALL** criteria **MUST** be met for approval. **ALL** documentation, including labs and/or chart notes (if required), **must** be submitted or request will be denied.

**Initial Authorization – 6 months.**

- ❑ Patient is 18 years old or older

**AND**

- ❑ Diagnosis of HIV-1 infection

**AND**

- ❑ This medication is being prescribed or in consultation with an Infectious Disease Specialist **OR** Specialist in HIV treatment

**AND**

- ❑ Patient has been treated with antiviral therapy for at least 6 months

**AND**

- ❑ Patient has been identified to have multidrug resistant HIV-1 infection with documented resistance to at least **ONE** antiretroviral medication from at least **three (3)** of the following antiretroviral drug classes **(must submit genotype/phenotype resistance testing results)**:
  - ❑ Nucleoside Reverse Transcriptase Inhibitors
  - ❑ Non-Nucleoside Reverse Transcriptase Inhibitors
  - ❑ Protease Inhibitors
  - ❑ Entry Inhibitors
  - ❑ Integrase Inhibitors
- ❑ Patient has a viral load greater than 1,000 copies/mL

  Current Viral Load: _____ copies/mL (**MUST** submit most recent lab work indicating viral load **prior to initiating therapy)**

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**AND**

- ❑ Provider confirms ibalizumab will be used in conjunction with an optimized background regiment for antiretroviral therapy.

**Reauthorization Approval - 12 months.** Criteria below **must** be met and **ALL** documentation (chart notes and or lab results) **must** be attached for approval of drug.

- ❑ Submission of documentation and/or lab work indicating patient has had a decrease in viral load since initiation of ibalizumab

  Viral Load: _____ copies/mL **after 6 months of treatment**

**AND**

- ❑ Prescriber confirms the patient has continued an optimized background regimen during ibalizumab therapy

***Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

**Previous therapies will be verified through pharmacy paid claims or submitted chart notes.**

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

**DEA OR NPI #:** _____

***Approved by Pharmacy and Therapeutics Committee:** 1/17/2019
**REVISED/UPDATED: 3/23/2019**