

# OPTIMA HEALTH COMMUNITY 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 1-844-348-3720.** 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<sup>®</sup> (ibalizumab-uiyk) IV (J1746) (Medical)

**DRUG INFORMATION:** Complete information below or authorization process 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 labwork indicating viral load **prior to initiating therapy**)

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**AND**

- Provider confirms ibalizumab will be used in conjunction with an optimized background regimen 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