OPTIMA HEALTH PLAN

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.**

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

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

MEDICATION WILL BE PROVIDED BY THE PHYSICIAN'S OFFICE

- ❑ **URGENT REVIEW. In checking this box, prescriber attests to the fact that by applying the standard review timeframe may seriously jeopardize the member's life, health, or ability to regain maximum function.**

- ❑ **STANDARD REVIEW**. In checking this box, the timeframe does **NOT** jeopardize the life or health of the member or the member's ability to regain maximum function and would **NOT** subject the member to severe pain.

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

Drug Form/Strength: _____

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

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

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria **must** be met for approval. To support **ALL** documentation, including lab results, diagnostics, and/or chart notes, **must** be provided or request will be denied.

Initial Authorization – 6 months.

- ❑ Member is 18 years old or older

AND

- ❑ Diagnosis of HIV-1 infection

AND

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

AND

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

AND

(Continued on next page)

- ❑ Member 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 **(genotype/phenotype resistance testing results included)**:
  - ❑ Nucleoside Reverse Transcriptase Inhibitors
  - ❑ Non-Nucleoside Reverse Transcriptase Inhibitors
  - ❑ Protease Inhibitors
  - ❑ Entry Inhibitors
  - ❑ Integrase Inhibitors
- ❑ Member has a viral load greater than 1,000 copies/mL

  Current Viral Load: _____ copies/mL (**recent lab work indicating viral load prior to initiating therapy must be included)**

AND

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

Reauthorization Approval - 12 months. Check below **ALL** that apply for approval. To support each line checked, **ALL** documentation (lab results, diagnostics, and/or chart notes) **must** be provided or request will be denied.

- ❑ 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 member 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.

Member 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;~~ **(Reformatted) 7/12/2019**