# 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)

**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)**:

**(Continued on next page)**

- ❑ 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)**

**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**