

SENTARA COMMUNITY PLAN (MEDICAID)

MEDICAL 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 1-844-305-2331. 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)

MEDICATION WILL BE PROVIDED BY THE PHYSICIAN'S OFFICE

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight: _____ Date: _____

- 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.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization – 6 months.

- Member is 18 years old or older

AND

- Diagnosis of HIV-1 infection

AND

(Continued on next page)

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

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

AND

- 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 (**must submit genotype/phenotype resistance testing results**):
 - 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 (**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 regimen for antiretroviral therapy.

Reauthorization Approval - 12 months. All criteria must be checked for approval. To support each line checked, all documentation (lab results, diagnostics, and/or chart notes) must be provided or request may 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 the member has continued an optimized background regimen during ibalizumab therapy

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****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.****