OPTIMA HEALTH PLAN

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 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process may be delayed.**

Drug Requested: Rukobia (fostemsavir)

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength/Month: _____

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

Diagnosis: _____ **ICD Code:** _____

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.

- ❑ Member is 18 years old or older

AND

- ❑ This medication is being prescribed by, or in consultation with, an infectious disease specialist or specialist in HIV treatment

AND

- ❑ The patient has been identified to have multidrug resistant HIV-1 infection with documented resistance to at least **FOUR** antiretroviral medications from **FIVE** 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 (including CCR5 antagonists)
  - ❑ Integrase Inhibitors

AND

- ❑ The patient is experiencing current virologic failure defined as having a viral load greater than 200 copies/mL
  - Current Viral Load: _____ copies/mL **(must submit most recent labwork indicating viral load prior to initiating therapy, within 4-8 weeks)**

AND

- ❑ The provider confirms fostemsavir will be used in conjunction with an optimized background regimen for antiretroviral therapy

(Continued on next page; signature page is required to process request.)

(Please ensure signature page is attached to form.)

Medication being provided by Specialty Pharmacy - PropriumRx

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****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**: 10/16/2020

REVISED/UPDATED: 12/7/2020;