# SENTARA HEALTH PLANS

## 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 1-844-668-1550**. 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: Fuzeon®** (enfuvirtide) **(J1324) (Medical)**

**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:** _____

**NPI #:** _____

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

**Drug Form/Strength:** _____

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

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

**Weight (if applicable):** _____ **Date weight obtained:** _____

❑ 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: 12 months**

❑ Member is 6 years of age or older

❑ Prescribed by or in consultation with an infectious disease specialist

**(Continued on next page)**

- ❑ Member has had trial and failure of at least 12 weeks of an antiretroviral therapy regimen which includes the following **(verified by chart notes or pharmacy paid claims)**:
  - ❑ **TWO** nucleoside analogue reverse transcriptase inhibitors
  - ❑ **ONE** agent from any of the following classes:
    - ❑ Integrase strand transfer inhibitor
    - ❑ Non-nucleoside analogue reverse transcriptase inhibitor
    - ❑ Boosted protease inhibitor
- ❑ Provider has submitted laboratory documentation (obtained within the past 30 days) showing members' HIV ribonucleic acid viral load ≥ 200 copies/mL
- ❑ Requested medication will be used concurrently with additional antiretroviral agents to which the member is susceptible (at least two additional active antiretroviral agents)
- ❑ Requested dose does **NOT** exceed 180 mg per day (90 mg subcutaneous twice daily)

**Reauthorization: 12 months.** 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.

- ❑ Provider has submitted documentation which shows the member is currently receiving enfuvirtide for HIV-1 infection and has received this medication for at least 30 days
- ❑ Member is experiencing a positive response to therapy
- ❑ Requested dose does **NOT** exceed 180 mg per day (90 mg subcutaneous twice daily)

**Medication being provided by (check applicable box(es) below):**

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy**

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.***



***Approved by Pharmacy and Therapeutics Committee**: 3/27/2025
**REVISED/UPDATED/REFORMATTED: 6/11/2025**