

I. Requirements for Prior Authorization of HIV/AIDS Antiretrovirals

A. Prescriptions That Require Prior Authorization

Prescriptions for HIV/AIDS Antiretrovirals that meet any of the following conditions must be prior authorized:

1. A non-preferred HIV/AIDS Antiretroviral. See the Preferred Drug List (PDL) for the list of preferred HIV/AIDS Antiretrovirals at: <https://papdl.com/preferred-drug-list>.
2. A non-nucleoside reverse-transcriptase inhibitor (NNRTI) when there is a record of a recent paid claim for another NNRTI (therapeutic duplication).
3. A protease inhibitor when there is a record of a recent paid claim for another protease inhibitor (exception: Norvir [ritonavir]) (therapeutic duplication).
4. An integrase strand transfer inhibitor when there is a record of a recent paid claim for another integrase strand transfer inhibitor (therapeutic duplication).
5. A single product regimen when there is a record of a recent paid claim for another single product regimen (therapeutic duplication).

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an HIV/AIDS Antiretroviral, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For a non-preferred HIV/AIDS Antiretroviral, **one** of the following:
 - a. Has a current history (within the past 90 days) of being prescribed the same non-preferred HIV/AIDS Antiretroviral (does not apply to non-preferred brands when the therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred)
 - b. **All** of the following:
 - i. Has a documented history of contraindication, intolerance, or lab test results showing resistance to the preferred HIV/AIDS Antiretrovirals with the same mechanism of action as the requested agent,
 - ii. Is prescribed the HIV/AIDS Antiretroviral for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication,
 - iii. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature;

AND

2. For therapeutic duplication, **one** of the following:
- a. For an NNRTI, is being transitioned to another NNRTI with the intent of discontinuing one of the medications,
 - b. For a protease inhibitor, is being transitioned to another protease inhibitor with the intent of discontinuing one of the medications,
 - c. For an integrase strand transfer inhibitor, is being transitioned to another integrase strand transfer inhibitor with the intent of discontinuing one of the medications,
 - d. For a single product regimen, is being transitioned to another single product regimen with the intent of discontinuing one of the medications,
 - e. Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed medical literature or national treatment guidelines;

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

B. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an HIV/AIDS Antiretroviral. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

NON-PREFERRED MEDICATION PRIOR AUTHORIZATION FORM (form effective 01/01/20)

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			NPI:	State license #:
LTC facility contact/phone:			Street address:	
Beneficiary name:			Suite #:	City/State/Zip:
Beneficiary ID#:	DOB:	Phone:	Fax:	

Please refer to <https://papdl.com/preferred-drug-list> for the list of preferred and non-preferred medications in each Preferred Drug List class.

Non-preferred medication name:		Dosage form:	Strength:
Directions:		Quantity:	Refills:
Diagnosis <i>(submit documentation)</i> :		Dx code <i>(required)</i> :	
Has the beneficiary taken the requested non-preferred medication in the past 90 days? <i>(submit documentation)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No			
Describe all applicable medical reasons the beneficiary cannot use the preferred medication(s) in the same Preferred Drug List class. Submit documentation (e.g., recent chart/clinic notes, diagnostic evaluations, lab results, etc.) supporting this non-preferred request.			
<input type="checkbox"/> Treatment failure or inadequate response with preferred medication(s) <i>(include drug name, dose, and start/stop dates)</i> :			

<input type="checkbox"/> Unacceptable side effects, hypersensitivities, or other intolerances to preferred medication(s) <i>(include description and drug name(s))</i> :			

<input type="checkbox"/> Contraindication to preferred medication(s) <i>(include description and drug name(s))</i> :			

<input type="checkbox"/> Unique clinical or age-specific indications supported by FDA approval or medical literature <i>(describe)</i> :			

<input type="checkbox"/> Absence of preferred medication(s) with appropriate formulation <i>(list medical reason formulation is required)</i> :			

<input type="checkbox"/> Drug-drug interaction with preferred medication(s) <i>(describe)</i> :			

<input type="checkbox"/> Other medical reason(s) the beneficiary cannot use the preferred medication(s) <i>(describe)</i> :			

<input type="checkbox"/> For renewal requests of previously approved medications, submit documentation of tolerability and beneficiary's clinical response.			

PLEASE FAX COMPLETED FORM TO HIGHMARK WHOLECARE – PHARMACY DIVISION

Prescriber Signature:	Date:
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