

### lt's Wholecare.

Updated: 08/2020 PARP Approved: 08/2020

# Prior Authorization Criteria Cidofovir

All requests for Cidofovir require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Coverage may be provided with a <u>diagnosis</u> of cytomegalovirus retinitis with HIV and the following criteria is met:

- o For Initial Therapy:
  - For immediate sight threatening lesion (within 1500 microns of the fovea)
    - Documentation the member has tried and failed or had an intolerance to intravitreal ganciclovir injections with oral valganciclovir (Valcyte)
    - Documentation that cidofovir will be used in combination with intravitreal ganciclovir
  - For peripheral lesions
    - Documentation the member has tried and failed or had an intolerance or contraindication to oral valganciclovir
- o For Chronic Maintenance Therapy
  - Documentation the member has tried and failed or had an intolerance or contraindication to oral valganciclovir
- Must be prescribed by or in consultation with an ophthalmologist
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- The member must not have any contraindications to therapy
- **Initial Duration of Approval:** 6 months
- Reauthorization Criteria
  - o Documentation from the prescriber indicating improvement in the condition
  - Documentation the member still has active lesions or a CD4 count < 100 cells/mm<sup>3</sup>
- **Reauthorization Duration of Approval:** 6 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.



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#### CIDOFOVIR PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health<sup>SM</sup> Pharmacy Services. **FAX:** (888) 245-2049

If needed, you may call to speak to a Pharmacy Services Representative.

Requesting Provider:		d, you may call to speak to a I VE: (800) 392-1147 Monday the	•				
Requesting Provider: Provider Specialty: Office Address: Office Address: Office Address: Office Phone: Office Phone: Office Pax:    MEMBER INFORMATION		<u> </u>		•	1		
Provider Specialty: Office Address: Office Phone: Office Fax:    MEMBER INFORMATION							
Office Address:    Office Fhone:	<u> </u>						
Member Name: Gateway ID:    Member weight:pounds orkg				Office Phone:			
Member Name: Gateway ID:    Member weight:				Office Fax:			
Member weight:pounds orkg   REQUESTED DRUG INFORMATION		MEMBER INFO	ORMATIO	N			
REQUESTED DRUG INFORMATION  Medication: Frequency: Is the member currently receiving requested medication? Yes Date Medication Initiated: No  Billing Information  This medication will be billed: At a pharmacy OR medically (if medically please provide a strong of the foreign of the service information  Name:  NPI: Address:  MEDICAL HISTORY (Complete for ALL requests)  Diagnosis: Cytomegalovirus Retinitis with HIV Other  Does the member have sight threatening lesions within 1500 microns of the fovea? Yes No  Will the requested medication be used in combination with another medication? Yes No  If yes please list the name of the medication:  CURRENT or PREVIOUS THERAPY  Status (Discontinued &				DOB:			
REQUESTED DRUG INFORMATION	Gateway ID:	Gateway ID:		Member weight:pounds or			
Medication:   Strength:   Duration:   Strength:   Duration:   Is the member currently receiving requested medication?   Yes   Date Medication Initiated:   No   Date Medication Initiated:   Date Medication In					kg		
Status (Discontinued & CURRENT or PREVIOUS THERAPY   Date Medication   Yes   Date Medication   No   Date Medication		REQUESTED DRUG	INFORM	ATION			
Is the member currently receiving requested medication?				Strength:			
No   Billing Information	Frequency:			Duration:			
Billing Information  This medication will be billed:	Is the member currently receiving requested medication?			Date Medication Initiated:			
This medication will be billed:	No						
medically (if medically please provide a   JCODE:			rmation				
Place of Service: Hospital Provider's office Member's home Other  Place of Service Information  Name: NPI: Address: Phone:  MEDICAL HISTORY (Complete for ALL requests)  Diagnosis: Cytomegalovirus Retinitis with HIV Other  Does the member have sight threatening lesions within 1500 microns of the fovea? Yes No  Will the requested medication be used in combination with another medication? Yes No  If yes please list the name of the medication:  CURRENT or PREVIOUS THERAPY  Status (Discontinued &	This medication will be billed: at a pharmacy <b>OR</b>						
Place of Service:		medically (if medicall	y please pro	ovide a			
Place of Service Information  Name:  Address:  MEDICAL HISTORY (Complete for ALL requests)  Diagnosis: Cytomegalovirus Retinitis with HIV Other  Does the member have sight threatening lesions within 1500 microns of the fovea? Yes No  Does the member have peripheral lesions? Yes No  Will the requested medication be used in combination with another medication? Yes No  If yes please list the name of the medication:  CURRENT or PREVIOUS THERAPY							
Name: Address:    NPI:							
Address:    Phone:		Place of Service	Informatio				
MEDICAL HISTORY (Complete for ALL requests)  Diagnosis:  Cytomegalovirus Retinitis with HIV  Other  Does the member have sight threatening lesions within 1500 microns of the fovea?  Yes  No  Will the requested medication be used in combination with another medication?  Yes  No  If yes please list the name of the medication:  CURRENT or PREVIOUS THERAPY							
Diagnosis: Cytomegalovirus Retinitis with HIV Other  Does the member have sight threatening lesions within 1500 microns of the fovea? Yes No  Does the member have peripheral lesions? Yes No  Will the requested medication be used in combination with another medication? Yes No  If yes please list the name of the medication:  CURRENT or PREVIOUS THERAPY  Status (Discontinued &	Address:			Phone:			
Diagnosis: Cytomegalovirus Retinitis with HIV Other  Does the member have sight threatening lesions within 1500 microns of the fovea? Yes No  Does the member have peripheral lesions? Yes No  Will the requested medication be used in combination with another medication? Yes No  If yes please list the name of the medication:  CURRENT or PREVIOUS THERAPY  Status (Discontinued &		MEDICAL HIGHORY (C					
Does the member have sight threatening lesions within 1500 microns of the fovea?  Yes No  Does the member have peripheral lesions?  No  Will the requested medication be used in combination with another medication?  Yes No  If yes please list the name of the medication:  CURRENT or PREVIOUS THERAPY  Status (Discontinued &				<b>LL</b> requests	<b>S</b> )		
Does the member have peripheral lesions?	Diagnosis:						
Will the requested medication be used in combination with another medication?   Yes No  If yes please list the name of the medication:  CURRENT or PREVIOUS THERAPY  Status (Discontinued &	Does the member have sigh	at threatening lesions within 15	500 microns	of the fovea	? Yes No		
If yes please list the name of the medication:  CURRENT or PREVIOUS THERAPY  Status (Discontinued &	Does the member have peri	pheral lesions? Yes Y	No				
CURRENT or PREVIOUS THERAPY  Status (Discontinued &	Will the requested medicati	on be used in combination wi	th another m	nedication?	Yes No		
Status (Discontinued &	If yes please list the name						
Status (Discontinued &							
Medication Name Strength/ Frequency Dates of Therapy Why/Current)	Medication Name	Strength/ Frequency	Dates of '	Therapy			
			7 <i>a</i> 1 <del>a 2 a 2 a 2 a 2 a 2 a 2 a 2 a 2 a 2 a </del>				

REAUTHORIZATION



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Has the member experienced a significant improveme. Please describe:  Does the member still have active lesions?  Yes				
What is the member's current CD4 cell count?cells/mm <sup>3</sup>				
SUPPORTING INFORMATION	ON or CLINICAL RATIONALE			
Prescribing Provider Signature	Date			
Trescribing Trovider Digitature	Bute			