Updated: 10/2018
PARP Approved: 10/2018

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 diagnosis of cytomegalovirus retinitis with HIV and the following criteria is met:

- 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
- 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**
  - Documentation from the prescriber indicating improvement in the condition
  - Documentation the member still has active lesions or a CD4 count < 100 cells/mm^3
- **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.

Gateway Health

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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[SM] Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Frequency:	Duration:	
Is the member currently receiving requested medication? ☐ Yes ☐ No		Date Medication Initiated:

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

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

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

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No
Please describe:
Does the member still have active lesions? ☐ Yes ☐ No

What is the member's current CD4 cell count? _____cells/mm^3

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date