HIGHMARK Delaware HEALTH OPTIONS

Updated: 08/2020
DMMA Approved: 08/2020

Request for Prior Authorization for Cidofovir
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

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

Cidofovir Prior Authorization Criteria:

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.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product 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 Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 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:
Health Options 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:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

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)

REAUTHORIZATION

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