Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☐ **Medicare Part D**

This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Trogarzo™ (ibalizumab-uiyk)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Drug information

☐ New request ☐ Continuation request

☐ Trogarzo 200mg/1.33mL Solution for Infusion

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

For this drug to be covered, the patient must meet the following criteria:

1. Must have a diagnosis of human immunodeficiency virus type-1 (HIV-1) infection in heavily treatment-experienced adults with multidrug resistant (MDR) HIV-1 infection failing their current ARV regimen.
2. Documentation of adherence and failure to greater than or equal to 3 antiretroviral drug classes as evidenced by genotype and phenotype.

Medically accepted indication

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 05/2018
Last reviewed 05/2019

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Human immunodeficiency virus type-1 (HIV-1) infection in heavily treatment-experienced adults with multidrug resistant (MDR) HIV-1 infection failing their current ARV regimen

☐ *Other – the patient's condition is:* _____

B. Does the member have documentation of adherence and failure to greater than 2 antiretroviral drug classes as evidenced by genotype and phenotype?

☐ Yes, optional description

If yes, has the patient had a trial with?

☐ Yes

☐ No

	Doses	**Dates**	**Outcome**
☐ Regimen 1			
☐ Regimen 2			
☐ Regimen 3			
☐ Regimen 4			

☐ Not all requirements are met – Below is rationale for use:

_____

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Trogarzo likely be the most effective option for this patient?

☐ No

☐ Yes, because: _____

If the patient is currently using Trogarzo, would changing the patient's current regimen likely result in adverse effects for the patient?

☐ No

☐ Yes, because: _____

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Updated 05/2018
Last reviewed 05/2019