PriorityHealth

Medical prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☐ **Commercial (Individual/Optimized)**
☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Trogarzo® (ibalizumab-uiyk)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____ Prov. Phone: _____ Prov. Fax: _____

Physician Address: _____

Physician NPI: _____ Contact Name: _____

Physician Signature: _____ Date: _____

Product and Billing Information

☐ New Request ☐ Continuation Request

Drug product: ☐ Trogarzo 200mg/1.33mL Solution

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Date of next dose (if applicable): _____

Dose:_____ **Dose Frequency**:_____

BSA (if applicable):_____

Weight (if applicable):_____

Place of administration:

☐ Physician's office

☐ Outpatient infusion

Facility: _____ NPI:_____ Fax:_____

☐ Home infusion

Agency: _____ NPI:_____ Fax:_____

Billing:

☐ Physician to buy and bill

☐ Facility to buy and bill

☐ Specialty Pharmacy

Pharmacy:_____ NPI:_____ Fax:_____

ICD-10 Diagnosis code(s): _____

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

Updated 05/2020
Last reviewed 05/2020

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

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.
    a. Must be used in combination with other ARV drugs, as a salvage regimen.
    b. Member must be treated currently treated with an optimized background antiviral regimen.

2. Documentation of adherence and failure to greater than or equal to 3 antiretroviral drug classes as evidenced by genotype and phenotype.
    a. Please submit adherence documentation of failed therapies to Priority Health.

3. Trogarzo initial and maintenance dosing must be in accordance with the FDA prescribing information: A single loading dose of 2000 mg administered IV followed by a maintenance dose of 800 mg every two weeks thereafter.
    a. Initial authorization is for no more than 6 months.

4. Must be used for the treatment an HIV-1 infection (documentation of a HIV-1 ICD10 code* within the last 12 months must be submitted to Priority Health).

* Approved ICD10 codes are provided in the Additional Information section.

For continuation, patient must have met the following requirements:

1. Provider must submit documentation that patient has achieved clinically significant viral response to Trogarzo therapy and the provider must submit confirmation that the patient has continued to take an optimized background antiretroviral regimen.
2. Trogarzo maintenance dosing is only covered at the FDA labeled maintenance dose.
3. A continuation of treatment authorization is for no more than 12 months.

Medicaid members: Requirement to receive the medication by home infusion.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

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 – rationale for use: _____

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

☐ Yes.
If yes, what has the patient had a trial with?

☐ No.

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

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

All fields must be complete and legible for review. Your office will receive a response via fax.
Updated 05/2020
Last reviewed 05/2020

Additional information

Duration of approval:

1. Initial authorization for coverage is for duration of 6 months.
2. For continuation of treatment after the initial authorization the duration of coverage is 12 months.

Approved ICD10 Codes for HIV

1. B20 - Human immunodeficiency virus [HIV] disease
2. Z21 - Asymptomatic human immunodeficiency virus [HIV] infection status

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

Updated 05/2020
Last reviewed 05/2020