Prior Authorization Review Panel

CHC-MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.
Policies submitted without this form will not be considered for review.

Plan: PA Health & Wellness	**Submission Date: 11/2021**
Policy Number: PHW.PDL.237	**Effective Date: 01/01/2020** **Revision Date: 10/2021**
Policy Name: HIV/AIDS Antiretrovirals	

Type of Submission – Check all that apply:

- ☐ **New Policy**
- ✓ **Revised Policy***
- ☐ **Annual Review - No Revisions**
- ✓ **Statewide PDL -** *Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.*

***All revisions to the policy must be highlighted using track changes throughout the document.**

Please provide any changes or clarifying information for the policy below:

Q1 2022: policy revised according to DHS revisions effective 01/03/2022

Name of Authorized Individual (Please type or print): **Venkateswara R. Davuluri, MD**	**Signature of Authorized Individual:**

Clinical Policy: HIV/AIDS Antiretrovirals

Reference Number: PHW.PDL.237
Effective Date: 01/01/2020
Last Review Date: 10/2021

Revision Log

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with PA Health and Wellness® that HIV/AIDS Antiretrovirals are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of HIV/AIDS Antiretrovirals

A. Prescriptions That Require Prior Authorization

Prescriptions for HIV/AIDS Antiretrovirals that meet any of the following conditions must be prior authorized:

1. A non-preferred HIV/AIDS Antiretroviral. See the Preferred Drug List (PDL) for the list of preferred HIV/AIDS Antiretrovirals at: https://papdl.com/preferred-drug-list.
2. A prescription for Cabenuva (cabotegravir/rilpivirine).
3. An HIV/AIDS Antiretroviral with a prescribed quantity that exceeds the quantity limit.
4. A non-nucleoside reverse-transcriptase inhibitor (NNRTI) when there is a record of a recent paid claim for another NNRTI (therapeutic duplication).
5. A protease inhibitor when there is a record of a recent paid claim for another protease inhibitor (exception: Norvir [ritonavir]) (therapeutic duplication).
6. An integrase strand transfer inhibitor when there is a record of a recent paid claim for another integrase strand transfer inhibitor (therapeutic duplication).
7. A single product regimen when there is a record of a recent paid claim for another single product regimen (therapeutic duplication).

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an HIV/AIDS Antiretroviral, the determination of whether the requested prescription is medically necessary will take into account whether the member:

1. For a non-preferred HIV/AIDS Antiretroviral, **one** of the following:

a. Has a current history (within the past 90 days) of being prescribed the same non-preferred HIV/AIDS Antiretroviral (does not apply to non-preferred brands when the therapeutically equivalent generic is preferred or to non-preferred generic when the therapeutically equivalent brand is preferred)

b. **All** of the following:

i. Has a documented history of contraindication, intolerance, or lab test results showing resistance to the preferred HIV/AIDS Antiretrovirals with the same mechanism of action as the requested agent**,**
ii. Is prescribed the HIV/AIDS Antiretroviral for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication,
iii. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature;

AND

2. For Cabenuva (cabotegravir/rilpivirine), **both** of the following:

a. Is prescribed Cabenuva (cabotegravir/rilpivirine) for an indication that is included in the FDA-approved package labeling OR medically accepted indication,
b. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature;

AND

3. For therapeutic duplication, **one** of the following:

a. For an NNRTI, is being transitioned to another NNRTI with the intent of discontinuing one of the medications,
b. For a protease inhibitor, is being transitioned to another protease inhibitor with the intent of discontinuing one of the medications,
c. For an integrase strand transfer inhibitor, is being transitioned to another integrase strand transfer inhibitor with the intent of discontinuing one of the medications,
d. For a single product regimen, is being transitioned to another single product regimen with the intent of discontinuing one of the medications,
e. Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines;

AND

4. If a prescription for an HIV/AIDS Antiretroviral is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override.

NOTE: If the member does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an HIV/AIDS Antiretroviral. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member.

D. **Approval Duration**: **12 months**

E. References

1. DHHS Panel on Antiretroviral Guidelines for Adults and Adolescents – A Working Group of the Office of AIDS Research Advisory Council (OARAC). Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Last Updated: December 18, 2019; Last Reviewed: December 18, 2019.
2. DHHS Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV. Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection. Last Updated: December 24, 2019; last reviewed December 24, 2019.

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020
Q1 2021: policy revised according to DHS revisions effective 01/05/2021	11/2020
Q1 2022: policy revised according to DHS revisions effective 01/03/2022	10/2021