



**GEORGIA MEDICAID FEE-FOR-SERVICE  
HUMAN IMMUNODEFICIENCY VIRUS (HIV) MEDICATIONS PA SUMMARY**

<b>Preferred (may not be all inclusive)</b>	<b>Non-Preferred</b>
Abacavir generic*	Abacavir/lamivudine/zidovudine generic
Atripla (efavirenz/emtricitabine/tenofovir disoproxil fumarate)*	Aptivus (tipranavir)
Descovy (emtricitabine/tenofovir alafenamide)*	Complera (emtricitabine/rilpivirine/tenofovir disoproxil fumarate)
Didanosine delayed-release generic*	Crixivan (indinavir)
Edurant (rilpivirine)	Fuzeon (enfuvirtide)
Emtriva (emtricitabine)*	Intelence (etravirine)
Epivir solution (lamivudine)*	Invirase (saquinavir)
Epzicom (abacavir)*	Lamivudine solution generic
Evotaz (atazanavir/cobicistat)	Lexiva (fosamprenavir)
Genvoya (elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide)*	Nevirapine suspension generic
Isentress (raltegravir)	Nevirapine extended-release generic
Kaletra (lopinavir/ritonavir)*	Odefsey (emtricitabine/rilpivirine/tenofovir alafenamide)
Lamivudine generic*	Selzentry (maraviroc)
Lamivudine/zidovudine generic*	Stribild (elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil fumarate)
Nevirapine immediate-release tablets generic*	Viramune XR (nevirapine extended-release)
Norvir (ritonavir)*	Vitekta (elvitegravir)
Prezcobix (darunavir/cobicistat)	
Prezista (darunavir)	
Rescriptor (delavirdine)*	
Reyataz (atazanavir)*	
Stavudine generic*	
Sustiva (efavirenz)*	
Tivicay (dolutegravir)*	
Triumeq (abacavir/dolutegravir/lamivudine)*	
Trizivir (abacavir/lamivudine/zidovudine)*	
Truvada (emtricitabine/tenofovir disoproxil fumarate)*	
Tybost (cobicistat)	
Videx Pediatric (didanosine)*	
Viracept (nelfinavir)*	
Viramune Suspension (nevirapine)*	



Viread (tenofovir disoproxil fumarate)*	
Ziagen Solution (abacavir)*	
Zidovudine generic*	

\*PA not required

**LENGTH OF AUTHORIZATION:** Varies

**NOTES:**

- ❖ PA approval may be considered for members when faxed documentation is submitted of continuation of therapy from another insurance plan or ADAP (AIDS Drug Assistance Program).
- ❖ If generic nevirapine extended-release is approved, the prior authorization (PA) will be issued for brand Viramune XR.

**PA CRITERIA:**

*Abacavir/lamivudine/zidovudine*

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, brand Trizivir, is not appropriate for the member.

*Aptivus*

- ❖ Approvable for members 2 years of age or older for treatment of HIV infection when used in combination with ritonavir and one or more other antiretrovirals

*AND*

- ❖ Member's HIV must be resistant to at least 2 other protease inhibitors (PIs).

*Complera and Odefsey*

- ❖ Approvable for prophylaxis following exposure to HIV.
- ❖ Approvable for members 12 years of age or older who weigh 35 kilograms or more for treatment of HIV infection

*AND*

- ❖ For treatment-naïve, physician must submit faxed documentation of member's baseline HIV-RNA level at  $\leq 100,000$  copies/mL. For treatment experienced, member must have consistent viral suppression (HIV RNA  $< 50$  copies/mL) for  $> 6$  months with no history of virologic failure

*AND*

- ❖ Prescriber must submit faxed documentation supporting member's history of medication noncompliance or prescriber must submit a written letter of medical necessity stating the reasons the preferred products, Edurant taken with Descovy or Truvada, are not appropriate for the member.

*Crixivan*

- ❖ Approvable for members 18 years of age or older for treatment of HIV infection when used in combination with ritonavir and one or more other antiretrovirals

*AND*



- ❖ Member's HIV must be resistant to at least 2 other protease inhibitors (PIs).

*Edurant*

- ❖ Approvable for prophylaxis following exposure to HIV when used in combination with other antiretrovirals.
- ❖ Approvable for members 12 years of age or older for treatment of HIV infection when used in combination with other antiretrovirals

*AND*

- ❖ For treatment-naïve, physician must submit faxed documentation of member's baseline HIV-RNA level at  $\leq 100,000$  copies/mL.

*Evotaz and Prezcobix*

- ❖ Approvable for members 12 years of age or older for treatment of HIV infection when used in combination with other antiretrovirals.

*Fuzeon*

- ❖ Approvable for prophylaxis following exposure to HIV when used in combination with other antiretrovirals.
- ❖ Approvable for members 6 years of age or older for treatment of HIV infection when used in combination with other antiretrovirals

*AND*

- ❖ Member must be HIV treatment-experienced and resistant to at least 2 other HIV treatments.

*Intence*

- ❖ Approvable for prophylaxis following exposure to HIV when used in combination with other antiretrovirals.
- ❖ Approvable for members 6 years of age or older for treatment of HIV infection when used in combination with other antiretrovirals

*AND*

- ❖ Member must be HIV treatment-experienced and resistant to at least 2 other non-nucleoside reverse transcriptase inhibitors (NNRTIs).

*Invirase*

- ❖ Approvable for members 2 years of age or older for treatment of HIV infection when used in combination with ritonavir and one or more other antiretrovirals

*AND*

- ❖ Member's HIV must be resistant to at least 2 other protease inhibitors (PIs).

*Isentress*

- ❖ Approvable for prophylaxis following exposure to HIV when used in combination with other antiretrovirals.
- ❖ Isentress tablets are approvable for members 6 years of age or older for treatment of HIV infection when used in combination with other antiretrovirals.
- ❖ Isentress chewable tablets and powder are approvable for members less than 12 years of age for treatment of HIV infection when used in combination with other antiretrovirals.



*Lamivudine Solution Generic*

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, brand Epivir Solution, is not appropriate for the member.

*Lexiva*

- ❖ Approvable for members 2 years of age or older for treatment of HIV infection when used in combination with ritonavir and one or more other antiretrovirals

*AND*

- ❖ Member's HIV must be resistant to at least 2 other protease inhibitors (PIs).

*Nevirapine Suspension Generic*

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, brand Viramune suspension, is not appropriate for the member.

*Nevirapine ER Generic and Viramune XR*

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, generic nevirapine immediate-release tablets, is not appropriate for the member.

*Prezista*

- ❖ Approvable for members 3 years of age or older for treatment of HIV infection when used in combination with other antiretrovirals.

*Selzentry*

- ❖ Approvable for prophylaxis following exposure to HIV when used in combination with other antiretrovirals.
- ❖ Approvable for members 16 years of age or older when used in combination with other antiretrovirals

*AND*

- ❖ Physician must submit faxed documentation of CCR5-topic HIV infection.

*Stribild*

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, Genvoya, is not appropriate for the member.

*Tybost*

- ❖ Approvable for members 18 years or older for treatment of HIV infection when used in combination with atazanavir or darunavir.

*Vitekta*

- ❖ Approvable for members 18 years or older for treatment of HIV infection when used in combination with ritonavir, another protease inhibitor and one or more other antiretrovirals

*AND*

- ❖ Member must be HIV treatment-experienced and unable to take other integrase strand transfer inhibitors (INSTIs).

**EXCEPTIONS:**

- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process.



- ❖ The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827.**

**PREFERRED DRUG LIST:**

- ❖ For online access to the Preferred Drug List (PDL), please go to <http://dch.georgia.gov/preferred-drug-lists>.

**PA and APPEAL PROCESS:**

- ❖ For online access to the PA process, please go to [www.dch.georgia.gov/prior-authorization-process-and-criteria](http://www.dch.georgia.gov/prior-authorization-process-and-criteria) and click on Prior Authorization (PA) Request Process Guide.

**QUANTITY LEVEL LIMITATIONS:**

- ❖ For online access to the current Quantity Level Limits (QLL), please go to [www.mmis.georgia.gov/portal](http://www.mmis.georgia.gov/portal), highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.