



## **GEORGIA MEDICAID FEE-FOR-SERVICE HIV-AIDS PA SUMMARY**

<b>Preferred (may not be all inclusive)</b>	<b>Non-Preferred</b>
Abacavir generic	Abacavir/lamivudine/zidovudine generic
Abacavir/lamivudine generic	Aptivus (tipranavir)
Apretude (cabotegravir)*	Complera (emtricitabine/rilpivirine/tenofovir disoproxil fumarate)
Atazanavir capsules generic	Fuzeon (enfuvirtide)
Biktarvy (bictegravir/emtricitabine/tenofovir alafenamide)	Intelence (etravirine)
Cabenuva (cabotegravir/rilpivirine)*	Invirase (saquinavir)
Cimduo (lamivudine/tenofovir disoproxil fumarate)	Lexiva (fosamprenavir)
Darunavir 600 mg, 800 mg tablets generic	Nevirapine extended-release generic
Delstrigo (doravirine/lamivudine/tenofovir disoproxil fumarate)	Norvir Solution (ritonavir)
Descovy (emtricitabine/tenofovir alafenamide)	Pifeltro (doravirine)
Dovato (dolutegravir/lamivudine)	Reyataz Powder (atazanavir)
Edurant (rilpivirine)*	Rukobia (fostemsavir)
Efavirenz tablets generic	Selzentry (maraviroc)
Efavirenz/emtricitabine/tenofovir disoproxil fumarate generic	Stavudine generic^
Emtriva (emtricitabine)	Stribild (elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil fumarate)
Epivir solution (lamivudine)	Sunlenca tablets (lenacapavir)
Evotaz (atazanavir/cobicistat)*	Symfi (efavirenz 600 mg/lamivudine/tenofovir disoproxil fumarate)
Genvoya (elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide)	Symfi Lo (efavirenz 400 mg/lamivudine/tenofovir disoproxil fumarate)
Isentress and Isentress HD (raltegravir)*	Temixys (lamivudine/tenofovir disoproxil fumarate)
Juluca (dolutegravir/rilpivirine)	Viracept (nelfinavir)
Lamivudine generic	
Lamivudine/zidovudine generic	
Lopinavir/ritonavir generic	
Nevirapine immediate-release tablets, suspension generic	
Norvir Powder (ritonavir)	
Odefsey (emtricitabine/rilpivirine/tenofovir alafenamide)*	
Prezcobix (darunavir/cobicistat)*	
Prezista 75 mg, 150 mg tablets, suspension (darunavir)*	
Ritonavir tablets generic	
Sustiva (efavirenz) capsules	
Symtuza (darunavir/cobicistat/emtricitabine/tenofovir alafenamide)	
Tenofovir disoproxil fumarate generic	
Tivicay (dolutegravir tablets)	



Tivicay PD (dolutegravir tablets for oral suspension)*	
Triumeq (dolutegravir/abacavir/lamivudine)	
Triumeq PD (dolutegravir/abacavir/lamivudine tablets for oral suspension)	
Trizivir (abacavir/lamivudine/zidovudine)	
Emtricitabine/tenofovir disoproxil fumarate generic	
Tybost (cobicistat)*	
Viread Powder and Tablets 150 mg, 200 mg, 250 mg (tenofovir disoproxil fumarate)	
Zidovudine generic	

\*preferred but requires PA; ^non-preferred but does not require PA

**LENGTH OF AUTHORIZATION:** Varies

**NOTE:**

- Prior authorization (PA) approval may be considered for continuation of therapy from another insurance plan or ADAP (AIDS Drug Assistance Program).
- Edurant, Evotaz, Isentress, Odefsey, Prezcobix, Prezista, Tivicay PD and Tybost are preferred but require prior authorization.

**PA CRITERIA:**

Abacavir/Lamivudine/Zidovudine Generic

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

Apretude

- ❖ Approvable for members 12 years of age or older for pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV who are HIV negative.

Aptivus and 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).

Cabenuva

- ❖ Approvable for members 12 years of age or older for the treatment of HIV infection who are virologically suppressed on a stable antiretroviral regimen with no history of treatment failure and with no known or suspected resistance to either cabotegravir or rilpivirine.

Complera

- ❖ 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, member's baseline HIV RNA level must be  $\leq 100,000$  copies/mL and baseline CD4+ cell count must be  $\geq 200$  cells/mm<sup>3</sup>. For treatment experienced, member must have consistent viral suppression (HIV RNA  $< 50$  copies/mL) for  $\geq 6$  months with no history of virologic failure

AND

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred products, Odefsey as well as Edurant taken with Descovy or emtricitabine/tenofovir disoproxil fumarate generic, are not appropriate for the member.

#### Edurant

- ❖ Approvable for prophylaxis following exposure to HIV when used in combination with other antiretrovirals.
- ❖ Approvable for members 12 years of age or older who weigh 35 kilograms or more for treatment of HIV infection when used in combination with other antiretrovirals.

AND

- ❖ For treatment-naïve, member's baseline HIV-RNA level must be  $\leq 100,000$  copies/mL and baseline CD4+ cell count must be  $\geq 200$  cells/mm<sup>3</sup>. For treatment experienced, member must have consistent viral suppression (HIV RNA  $< 50$  copies/mL) for  $\geq 6$  months with no history of virologic failure.

#### 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).

#### 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.



Isentress HD

- ❖ Approvable for prophylaxis following exposure to HIV when used in combination with other antiretrovirals.
- ❖ Approvable for members 18 years of age or older for treatment of HIV infection who are treatment-naïve or virologically suppressed on Isentress 400 mg twice daily when used in combination with other antiretrovirals.
- ❖ Approvable for members less than 18 years of age and weigh 40 kg or greater for treatment of HIV infection who are treatment-naïve or virologically suppressed on Isentress 400 mg twice daily when used in combination with other antiretrovirals.

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 ER Generic

- ❖ 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.

Norvir Solution

- ❖ Approvable for members who are unable to swallow solid oral dosage formulations (i.e., tablets) and requires a dose that cannot be obtained by generic ritonavir tablets and brand Norvir Powder.

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, member's baseline HIV RNA level must be  $\leq 100,000$  copies/mL and baseline CD4+ cell count must be  $\geq 200$  cells/mm<sup>3</sup>. For treatment experienced, member must have consistent viral suppression (HIV RNA < 50 copies/mL) for  $\geq 6$  months with no history of virologic failure.

Pifeltro

- ❖ Approvable for members 18 years of age or older for treatment of HIV infection who are treatment-naïve or are virologically suppressed (HIV RNA <50 copies/mL) on a stable antiretroviral regimen with no history of treatment failure and are resistant to or have an allergy, contraindication, drug-drug interaction or intolerable side effect to bictegravir, emtricitabine or tenofovir alafenamide (Biktarvy) as well as lamivudine or tenofovir disoproxil fumarate (in Delstrigo).
- ❖ Must be used in combination with one or more other antiretrovirals.

Prezista 75 mg, 150 mg Tablets, Suspension

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



### Reyataz Powder

- ❖ Approvable for members 3 month of age or older for treatment of HIV infection who weigh 5 kg to less than 25 kg or who weigh 25 kg or more and are unable to swallow solid oral dosage formulations (i.e., capsules, tablets).

### Rukobia

- ❖ Approvable for members 18 years of age or older for treatment of HIV infection, when used in combination with other antiretroviral(s), who are heavily treatment-experienced with multidrug-resistant HIV-1 infection failing their current antiretroviral regimen due to resistance, intolerance or safety considerations and who have a viral load (HIV RNA)  $\geq 400$  copies/mL and  $\leq 2$  classes of antiretroviral medications remaining.

### Selzentry

- ❖ Approvable for prophylaxis following exposure to HIV when used in combination with other antiretrovirals.
- ❖ Selzentry tablets are approvable for members 2 years of age or older for treatment of CCR5-tropic HIV infection when used in combination with other antiretrovirals.
- ❖ Selzentry oral solution is approvable for members 2 to 11 years of age for treatment of CCR5-tropic HIV infection when used in combination with other antiretrovirals, and for members 12 years of age or older who are unable to swallow solid oral dosage formulations (i.e., capsules, tablets) when used in combination with other antiretrovirals.

### Stribild

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

### Sunlenca

- ❖ Approvable for members 18 years of age or older for treatment of HIV infection, when used in combination with other antiretroviral(s), who are heavily treatment-experienced with multidrug-resistant HIV-1 infection failing their current antiretroviral regimen due to resistance, intolerance or safety considerations and who have a viral load (HIV RNA)  $\geq 400$  copies/mL and  $\leq 2$  classes of antiretroviral medications remaining.

### Symfi and Symfi Lo

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the individual preferred products, efavirenz generic, lamivudine generic and tenofovir disoproxil fumarate generic taken together, are not appropriate for the member.

### Temixys

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred products, Cimduo and lamivudine generic with tenofovir disoproxil fumarate generic, are not appropriate for the member.

### Tivicay PD

- ❖ Approvable for members 4 weeks to 17 years of age who weigh 3 kg to 19 kg.
- ❖ Approvable for members 4 weeks to 17 years of age who weigh 20 kg to 24 kg and are unable to swallow solid oral dosage formulations (i.e., capsules, tablets).



Tybost

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

Viracept

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

*AND*

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

**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 Pharmacy and click on [Other Documents](#), then select the most recent quarters QLL list.