# Clinical Policy: Infectious Disease Agents: Antivirals - HIV

Reference Number: OH.PHAR.PPA.73
Effective Date: 01/01/2020
Last Review Date: N/A
Line of Business: Medicaid

Coding Implications
Revision Log

**See Important Reminder at the end of this policy for important regulatory and legal information.**

**Description:**
*See Appendix A for list of medications requiring prior authorization.*

**FDA Approved Indication(s):**
For the treatment of human immunodeficiency virus (HIV) infection.

**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 Buckeye Health Plan, an affiliate of Centene Corporation®, that Crixivan, Invirase, Lexiva, Viracept, Aptivus, Symtuza, Videx, Epivir, Combivir, Zerit, Ziagen, Viread 250mg tablets and oral powder, Edurant, Intelence, Nevirapine IR, Nevirapine ER, Rescriptor, Selzentry, Fuzeon, Stribild, and Tybost are **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria**

**A. For Crixivan, Invirase, Lexiva, Viracept, Aptivus, Symtuza, Videx, Epivir, Combivir, Zerit, Ziagen, Viread 250mg tablets & oral powder, Edurant, Intelence, Nevirapine IR, Nevirapine ER, Rescriptor, Selzentry, and Tybost** (must meet all)**:**

1. Diagnosis of HIV-1 infection;
2. Member must meet labeled age requirements for the medication;
3. Documentation that there has been a therapeutic failure to no less than a 30 day trial of at least one medication not requiring prior approval UNLESS there is a reason the member cannot be changed to a preferred medication. Acceptable reasons include:
   - Allergies to all medications not requiring prior approval.
   - Contraindication to or drug-to-drug interaction with medications not requiring prior approval.
   - History of unacceptable/toxic side effects to meds not requiring prior approval.
4. For Symtuza: Request must document clinical justification for the member's inability to use the individual components (Prezcobix and Descovy).

***NOTE – Grandfathering:* Members who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug through the automated PA system. Members who have taken the drug in the previous 120 days, but do not have claims history (e.g. new to Medicaid), will be approved for PA after prescriber contact.

**Approval duration:** 12 months.

**B. For Stribild** (must meet all)**:**
1. Diagnosis of HIV-1 infection;
2. Age ≥ 18 years OR children and adolescents 12 to 17 years weighing 35 kg or more;
3. Prescribed as monotherapy for HIV-1 infection;
4. Member is treatment naïve OR stable on an antiretroviral regimen for at least 6 months and is virologically suppressed (current HIV-1 RNA <50 copies/mL);
5. Submission of resistance test (dated within the past 3 months) demonstrating virologic susceptibility to **ALL** of the following components of Stribild: elvitegravir, emtricitabine, and tenofovir;
6. Documentation that there has been a therapeutic failure to no less than a 30 day trial of at least one medication not requiring prior approval and within the same class UNLESS there is a reason the member cannot be changed to a preferred medication. Acceptable reasons include:
   - Allergies to all medications not requiring prior approval.
   - Contraindication to or drug-to-drug interaction with medications not requiring prior approval.
   - History of unacceptable/toxic side effects to medications not requiring prior approval.

***NOTE – Grandfathering:* Members who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug through the automated PA system. Members who have taken the drug in the previous 120 days, but do not have claims history (e.g. new to Medicaid), will be approved for PA after prescriber contact.

**Approval duration:** 12 months.

**C. For Fuzeon** (must meet all)**:**
1. Diagnosis of HIV-1 infection;
2. Age ≥ 6 years;
3. Fuzeon is prescribed concurrently with additional antiretroviral agents to which member is susceptible;
4. Documentation that there has been a therapeutic failure to no less than a 30 day trial of at least one medication not requiring prior approval UNLESS there is a reason the member cannot be changed to a preferred medication. Acceptable reasons include:
   - Allergies to all medications not requiring prior approval.
   - Contraindication to or drug-to-drug interaction with medications not requiring prior approval.
   - History of unacceptable/toxic side effects to medications not requiring prior approval.

***NOTE – Grandfathering:* Members who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug through the automated PA system. Members who have taken the drug in the previous 120 days, but do not have claims history (e.g. new to Medicaid), will be approved for PA after prescriber contact.

**Approval duration:** 12 months.

**D. Other diagnoses/indications:**

1. There are no pharmacy and therapeutic committee approved off-label use criteria for the diagnosis;
2. Use is supported by one of the following (a, b, or c):
   a. The National Comprehensive Cancer Network (NCCN) Drug Information and Biologics Compendium level of evidence 1 or 2A;
   b. Evidence from at least two high-quality, published studies in reputable peer-reviewed journals or evidence-based clinical practice guidelines that provide all of the following (i – iv):
      i. Adequate representation of the member's clinical characteristics, age, and diagnosis;
      ii. Adequate representation of the prescribed drug regimen;
      iii. Clinically meaningful outcomes as a result of the drug therapy in question;
      iv. Appropriate experimental design and method to address research questions;
   c. Micromedex DrugDex® with strength of recommendation Class I, IIa, or IIb;
3. Prescribed by or in consultation with an appropriate specialist for the diagnosis;
4. Failure of an adequate trial of at least two FDA-approved drugs for the indication and/or drugs that are considered the standard of care, when such agents exist for the same indication at maximum indicated doses, unless no such drugs exist, at maximum indicated doses, unless contraindicated or clinically significant adverse effect are experienced;
5. Dosing regimen and duration are within dosing guidelines recommended by clinical practice guidelines and/or medical literature.

**Approval duration:** 12 months.

**II. Diagnoses/Indications for which coverage is NOT authorized:**

Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 for Medicaid or evidence of coverage documents.

**III. Appendices/General Information**

*Appendix A: Medications requiring prior authorization*

**HIV PROTEASE INHIBITORS AND COMBINATIONS**

| NO PA REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|
| EVOTAZ® (atazanavir/cobicistat) | CRIXIVAN® (indinavir sulfate) |
| KALETRA® (lopinavir/ritonavir) | INVIRASE® (saquinavir mesylate) |
| REYATAZ® capsules, oral powder (atazanavir sulfate) | LEXIVA® (fosamprenavir calcium) |
| | VIRACEPT® (nelfinavir mesylate) |

### HIV NON-PEPTIDIC PROTEASE INHIBITORS AND COMBINATIONS

| NO PA REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|
| PREZCOBIX® (darunavir/cobicistat)<br>PREZISTA® (darunavir ethanolate) | APTIVUS® (tipranavir; tipranavir/vitamin E)<br>SYMTUZA™ (darunavir, cobicistat, emtricitabine, tenofovir alafenamide) † |

† Request must address use of the individual components PREZCOBIX and DESCOVY

### HIV REVERSE TRANSCRIPTASE INHIBITORS, NUCLEOSIDE ANALOGS AND COMBINATIONS

| NO PA REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|
| ABACAVIR SULFATE tablet (generic of Ziagen®)<br>ABACAVIR/LAMIVUDINE (generic of Epzicom®)<br>EMTRIVA® (emtricitabine)<br>ABACAVIR/LAMIVUDINE/ZIDOVUDINE (generic TRIZIVIR®)<br>ZIDOVUDINE (generic of Retrovir®) | DIDANOSINE capsule (generic of Videx®)<br>LAMIVUDINE solution, tablet (generic of Epivir®)<br>LAMIVUDINE/ZIDOVUDINE (generic of Combivir®)<br>STAVUDINE (generic of Zerit®)<br>VIDEX® solution (didanosine) |

### HIV REVERSE TRANSCRIPTASE INHIBITORS, NUCLEOTIDE ANALOGS

| NO PA REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|
| VIREAD® 150 mg (tenofovir disoproxil fumarate)<br>TENOFOVIR DISOPROXIL 300mg (generic for VIREAD®) | VIREAD® 250mg & Oral Powder (tenofovir disoproxil fumarate) |

### HIV REVERSE TRANSCRIPTASE INHIBITORS, NON-NUCLEOSIDE ANALOGS

| NO PA REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|
| EFAVIRENZ (generic for SUSTIVA®)<br>PIFELTRO™ (doravirine) | EDURANT® (rilpivirine)<br>INTELENCE® (etravirine)<br>NEVIRAPINE ER (generic of Viramune® XR)<br>NEVIRAPINE IR (generic of Viramune®)<br>RESCRIPTOR® (delavirdine mesylate) |

### HIV INTEGRASE STRAND TRANSFER INHIBITORS

| NO PA REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|
| ISENTRESS® tablets, chewable tablet, powder packets (raltegravir potassium)<br>TIVICAY® (dolutegravir sodium) | |

### HIV CCR5 CO-RECEPTOR ANTAGONISTS

| NO PA REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|
| | SELZENTRY® (maraviroc) |

**HIV FUSION INHIBITORS**

| NO PA REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|
| | FUZEON® (enfuvirtide) |

**HIV RTI, NUCLEOSIDE-NUCLEOTIDE ANALOGS**

| NO PA REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|
| DESCOVY® (emtricitabine/ tenofovir alafenamide)<br>CIMDUO™ (lamivudine/tenofovir)<br>TRUVADA® (emtricitabine/tenofovir) | |

**HIV RTI, NUCLEOSIDE-NUCLEOTIDE ANALOGS AND COMBINATIONS**

| NO PA REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|
| DELSTRIGO™ (doravirine, lamivudine, and tenofovir disoproxil)<br>SYMFI & SYMFI LO™ (efavirenz/lamivudine/tenofovir) | |

**HIV RTI, NUCLEOSIDE, NUCLEOTIDE, & NON-NUCLEOSIDE ANALOGS**

| NO PA REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|
| ATRIPLA® (emtricitabine/efavirenz/tenofovir)<br>COMPLERA® (emtricitabine/rilpivirine/tenofovir)<br>ODEFSEY® (emtricitabine/rilpivirine/tenofovir alafenamide) | |

**HIV INTEGRASE INHIBITOR & RTI COMBINATION**

| NO PA REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|
| DOVATO (dolutegravir/lamivudine) †<br>GENVOYA® (elvitegravir, cobicistat, emtricitabine, and tenofovir alafenamide)<br>TRIUMEQ® (dolutegravir/abacavir/lamivudine) | STRIBILD® (elvitegravir/cobicistat/emtricitabine/ tenofovir) |

**HIV INTEGRASE INHIBITOR & NUCLEOSIDE ANALOG COMBINATIONS**

| NO PA REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|
| BIKTARVY® (bictegravir/emtricitabine/tenofovir) | |

**HIV INTEGRASE INHIBITOR & NON-NUCLEOSIDE COMBINATION**

| NO PA REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|
| JULUCA (dolutegravir/rilpivirine) | |

**HIV PHARMACOKINETIC ENHANCERS (CYP3A INHIBITORS)**

| NO PA REQUIRED "PREFERRED" | PA REQUIRED "NON-PREFERRED" |
|---|---|
| RITONAVIR (generic for Norvir®)<br>NORVIR® oral Solution (ritonavir)<br>NORVIR® oral Powder (ritonavir) | TYBOST® (cobicistat) |

*Appendix B: Abbreviation/Acronym Key*
CCR5: C-C chemokine receptor type 5
CYP3A: Cytochrome P4503A
ER: Extended Release
FDA: Food and Drug Administration
HIV: Human Immunodeficiency Virus
IR: Immediate Release
PA: Prior Authorization
RNA: Ribonucleic Acid

*Appendix C: Therapeutic Alternatives*
*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.*

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| EVOTAZ® (atazanavir/cobicistat) | 1 tablet once daily | 300 mg/150 mg daily |
| KALETRA® (lopinavir/ritonavir) | 400 mg/100 mg twice daily | 800 mg/200 mg per day |
| REYATAZ® capsules, oral powder (atazanavir sulfate) | 300 mg w/ ritonavir 100 mg daily; alternatively 400 mg daily if unable to tolerate ritonavir | 300 mg/day w/ ritonavir & 400 mg/day without ritonavir |
| PREZCOBIX® (darunavir/cobicistat) | 1 tablet once daily | 800 mg/150 mg daily |
| PREZISTA® (darunavir ethanolate) | Treatment-naïve or treatment-experienced w/ no darunavir resistance: 800 mg daily w/ ritonavir 100 mg daily<br><br>Treatment-experienced w/ at least one darunavir resistance: 600 mg twice daily w/ ritonavir 100 mg twice daily | 1200 mg/day |
| ABACAVIR SULFATE tablet (generic of Ziagen®) | 300 mg twice daily or 600 mg once daily | 600 mg/day |

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| ABACAVIR/LAMIVUDINE (generic of Epzicom®) | 1 tablet once daily | Abacavir 600 mg/day; lamivudine 300 mg/day |
| EMTRIVA® (emtricitabine) | Capsules: 200 mg once daily<br><br>Oral solution: 240 mg once daily | 200 mg/day for capsules; 240 mg/day for oral solution |
| ABACAVIR/LAMIVUDINE/ZIDOVUDINE (generic TRIZIVIR®) | 1 tablet twice daily | Abacavir 600 mg/day; lamivudine 300 mg/day; zidovudine 600 mg/day |
| ZIDOVUDINE (generic of Retrovir®) | 300 mg twice daily or 200 mg three times daily | 600 mg/day |
| VIREAD® 150 mg (tenofovir disoproxil fumarate) | 1 tablet once daily | 300 mg/day |
| TENOFOVIR DISOPROXIL 300mg (generic for VIREAD®) | 1 tablet once daily | 300 mg/day |
| EFAVIRENZ (generic for SUSTIVA®) | 600 mg once daily at bedtime | 600 mg/day |
| PIFELTRO™ (doravirine) | No concurrent treatment with rifabutin: 1 tablet once daily<br><br>Concurrent treatment with rifabutin: 1 tablet every 12 hours for the duration of rifabutin concurrent therapy | 100 mg/day; 200 mg/day if given with rifabutin |
| ISENTRESS® tablets, chewable tablet, powder packets (raltegravir potassium) | 400 mg tablet: 400 mg twice daily. During coadministration with rifampin, the recommended dosage is 800 mg twice daily<br><br>600 mg tablet: 1,200 mg once daily | 800 mg/day for the 400 mg film-coated tablet; 1,600 mg/day with concomitant rifampin; 1,200 mg/day for the 600 mg film-coated tablet |
| TIVICAY® (dolutegravir sodium) | Treatment-naive or treatment-experienced but integrase strand | 100 mg/day |

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| | transfer inhibitor naive: 50 mg once daily<br><br>Coadministration w/ efavirenz, fosamprenavir & ritonavir, tipranavir & ritonavir, carbamazepine, or rifampin: 50 mg twice daily | |
| DESCOVY® (emtricitabine/ tenofovir alafenamide) | 1 tablet once daily | 1 tablet/day |
| CIMDUO™ (lamivudine/tenofovir) | 1 tablet once daily | 1 tablet/day |
| TRUVADA® (emtricitabine/tenofovir) | 1 tablet once daily | 200 mg/day emtricitabine and 300 mg/day tenofovir DF |
| DELSTRIGO™ (doravirine, lamivudine, and tenofovir disoproxil) | No concurrent treatment with rifabutin: 1 tablet once daily<br><br>Concurrent treatment w/ rifabutin: 1 tablet (doravirine 100 mg; lamivudine 300 mg; tenofovir disoproxil fumarate 300 mg) daily. 12 hours later give additional 100 mg of doravirine each day | Doravirine 100 mg/day; lamivudine 300 mg/day; tenofovir disoproxil fumarate 300 mg/day. If given with rifabutin, doravirine 200 mg/day; lamivudine 300 mg/day; tenofovir disoproxil fumarate 300 mg/day |
| SYMFI & SYMFI LO™ (efavirenz/lamivudine/tenofovir) | Symfi: 1 tablet once daily at bedtime<br><br>Symfi Lo: 1 tablet once daily at bedtime | Efavirenz 600 mg/day; lamivudine 300 mg/day; tenofovir DF 300 mg/day<br><br>Efavirenz 400 mg/day; lamivudine 300mg/day; tenofovir DF 300 mg/day |
| ATRIPLA® (emtricitabine/efavirenz/tenofovir) | 1 tablet once daily at bedtime | 1 tablet/day |

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| COMPLERA® (emtricitabine/rilpivirine/tenofovir) | 1 tablet once daily | 1 tablet/day |
| ODEFSEY® (emtricitabine/rilpivirine/tenofovir alafenamide) | 1 tablet once daily | 1 tablet/day |
| DOVATO (dolutegravir/lamivudine) | Treatment-naïve: 1 tablet (50 mg dolutegravir; 300 mg lamivudine) daily<br><br>Coadministration with carbamazepine or rifampin: 1 tablet (50 mg dolutegravir; 300 mg lamivudine) daily. 12 hours later give additional 50 mg of dolutegravir | 1 tablet/day (dolutegravir 50 mg/day; lamivudine 300 mg/day); dolutegravir 100 mg/day when coadministered with certain drugs |
| GENVOYA® (elvitegravir, cobicistat, emtricitabine, and tenofovir alafenamide) | 1 tablet once daily | 1 tablet/day |
| TRIUMEQ® (dolutegravir/abacavir/lamivudine) | 1 tablet (600 mg abacavir; 50 mg dolutegravir; 300 mg lamivudine) once daily<br><br>Coadministration with efavirenz, fosamprenavir/ritonavir, tipranavir/ritonavir, carbamazepine, or rifampin: 1 tablet (600 mg abacavir; 50 mg dolutegravir; 300 mg lamivudine) daily. 12 hours later give additional 50 mg of dolutegravir | 1 tablet/day (abacavir 600 mg/day; dolutegravir 50 mg/day; lamivudine 300 mg/day); dolutegravir 100 mg/day when coadministered with certain drugs |
| BIKTARVY® (bictegravir/emtricitabine/tenofovir) | 1 tablet once daily | 1 tablet/day |
| JULUCA (dolutegravir/rilpivirine) | No concurrent treatment with rifabutin: 1 tablet once daily | dolutegravir 50 mg/day; rilpivirine 25 mg/day; rilpivirine 50 mg/day when |

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| | Concurrent treatment w/ rifabutin: 1 tablet (dolutegravir 50 mg; rilpivirine 25 mg) plus an additional 25 mg tablet of rilpivirine (total daily rilpivirine dose of 50 mg) once daily | administered with rifabutin |
| RITONAVIR (generic for Norvir®) | 600 mg twice daily | 1200 mg/day |
| NORVIR® oral Solution (ritonavir) | 600 mg twice daily | 1200 mg/day |
| NORVIR® oral Powder (ritonavir) | 600 mg every 12 hours | 1200 mg/day |

*Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.*

*Appendix D: Contraindications/Boxed Warnings*

- Contraindication(s):
  - AV Block
  - Hepatic Disease
  - Hypokalemia
  - Hypomagnesemia
  - QT Prolongation
  - Torsade de Pointes

- Boxed warning(s):
  - Bone Marrow Supression
  - Hepatitis B Exacerbation
  - Hepatotoxicity
  - Intracranial Bleeding
  - Myopathy

## IV. Dosage and Administration

- Varies by drug product. See FDA approved dosing and administration AND Appendix C.

## V. Product Availability

| Drug Name | Availability |
|---|---|
| Abacavir | Oral solution: 20 mg/mL |
| Abacavir | Tablets: 300 mg |
| Abacavir/Lamivudine | Tablets: 600 mg-300 mg |
| Abacavir/Lamivudine/Zidovudine | Tablets: 300 mg-150 mg-300 mg |
| Aptivus | Capsules: 250 mg |

| Drug Name | Availability |
|---|---|
| Aptivus | Oral solution: 100 mg/mL |
| Atazanavir | Capsules: 150 mg, 200 mg, 300 mg |
| Atripla | Tablets: 600 mg-200 mg-300 mg |
| Biktarvy | Tablets: 50 mg-200 mg-25 mg |
| Cimduo | Tablets: 300 mg-300 mg |
| Complera | Tablets: 200 mg-25 mg-300 mg |
| Crixivan | Capsules: 200 mg, 400 mg |
| Delstrigo | Tablets: 100 mg-300 mg-300 mg |
| Descovy | Tablets: 200 mg-25 mg |
| Didanosine | Capsules: 125 mg, 200 mg, 250 mg, 400 mg |
| Dovato | Tablets: 50 mg-300 mg |
| Edurant | Tablets: 25 mg |
| Efavirenz | Capsules: 50 mg, 200 mg |
| Efavirenz | Tablets: 600 mg |
| Emtriva | Capsules: 200 mg |
| Emtriva | Oral solution: 10 mg/mL |
| Evotaz | Tablets: 300 mg-150 mg |
| Fosamprenavir Calcium | Tablets: 700 mg |
| Fuzeon | Solution for injection: 90 mg |
| Genvoya | Tablets: 150 mg-150 mg-200 mg-10 mg |
| Intelence | Tablets: 25 mg, 100 mg, 200 mg |
| Invirase | Tablets: 500 mg |
| Isentress | Chewable Tablets: 25 mg, 100 mg |
| Isentress | Granules for suspension: 100 mg |
| Isentress | Tablets: 400 mg |
| Isentress HD | Tablets: 600 mg |
| Juluca | Tablets: 50 mg-25 mg |
| Kaletra | Tablets: 100 mg-25 mg, 200 mg-50 mg |
| Lamivudine | Oral solution: 10 mg/mL |
| Lamivudine | Tablets: 150 mg, 300 mg |
| Lamivudine/Zidovudine | Tablets: 150 mg-300 mg |
| Lexiva | Oral suspension: 50 mg/mL |
| Lopinavir/Ritonavir | Oral solution: 80 mg-20 mg/mL |
| Nevirapine | Oral suspension: 50 mg/5 mL |
| Nevirapine IR | Tablets: 200 mg |
| Nevirapine ER | Tablets: 100 mg, 400 mg |
| Norvir | Capsules: 100 mg |
| Norvir | Oral powder: 100 mg |
| Norvir | Oral solution: 80 mg/mL |
| Odefsey | Tablets: 200 mg-25 mg-25 mg |
| Pifeltro | Tablets: 100 mg |
| Prezcobix | Tablets: 800 mg-150 mg |
| Prezista | Oral suspension: 100 mg/mL |
| Prezista | Tablets: 75 mg, 150 mg, 600 mg, 800 mg |

| Drug Name | Availability |
|---|---|
| Rescriptor | Tablets: 200 mg |
| Retrovir | Solution for injection: 10 mg/mL |
| Reyataz | Oral powder: 50 mg |
| Ritonavir | Tablets: 100 mg |
| Selzentry | Oral solution: 20 mg/mL |
| Selzentry | Tablets: 25 mg, 75 mg, 150 mg, 300 mg |
| Stavudine | Oral powder: 1 mg/mL |
| Stavudine | Capsules: 15 mg, 20 mg, 30 mg, 40 mg |
| Stribild | Tablets: 150 mg-150 mg-200 mg-300 mg |
| Symfi | Tablets: 600 mg-300 mg-300 mg |
| Symfi Lo | Tablets: 400 mg-300 mg-300 mg |
| Symtuza | Tablets: 800 mg-150 mg-200 mg-10 mg |
| Tenofovir Disoproxil Fumarate | Tablets: 300 mg |
| Tivicay | Tablets: 10 mg, 25 mg, 50 mg |
| Triumeq | Tablets: 600 mg-50 mg-300 mg |
| Truvada | Tablets: 100 mg-150 mg, 133 mg-200 mg, 167 mg-250 mg, 200 mg-300 mg |
| Tybost | Tablets: 150 mg |
| Videx | Oral powder: 2 g |
| Viracept | Oral suspension: 50 mg/g |
| Viracept | Tablets: 250 mg, 625 mg |
| Viread | Oral powder: 40 mg/scoop |
| Viread | Tablets: 150 mg, 200 mg, 250 mg, 300 mg |
| Zidovudine | Capsules: 100 mg |
| Zidovudine | Oral solution: 50 mg/5 mL |
| Zidovudine | Tablets: 300 mg |

## VI. References


- Abacavir. Clinical Pharmacology. Elsevier. Tampa, FL. Available at https://www.clinicalpharmacology-ip.com. Accessed November 12, 2019.
- Efavirenz. Clinical Pharmacology. Elsevier. Tampa, FL. Available at https://www.clinicalpharmacology-ip.com. Accessed November 12, 2019.
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- Fuzeon (enfuvirtide) [package insert]. San Francisco, CA; Genentech Inc.; Revised 12/2018.
- Lamivudine. Clinical Pharmacology. Elsevier. Tampa, FL. Available at https://www.clinicalpharmacology-ip.com. Accessed November 12, 2019.
- Stribild (elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil fumarate) [package insert]. Foster City, CA; Gilead Sciences Inc.; Revised 01/2019.

| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|---|---|---|
| New policy created. | 10.19 | N/A |

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

**Note:**
**For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.