Reference number(s)
4990-D

This document applies to the following:

Formulary	Applies
Standard Control (SF)	☐
Standard Control – Choice (SCCF)	☐
Preferred Drug Plan Design (PDPD)	☐
Advanced Control Specialty (ACSF)	☐
Advanced Control Specialty – Choice (ACSCF)	☐
Managed Medicaid Template (MMT)	☐
Marketplace (MF)	☐
Aetna Small Group Affordable Care Act (SG ACA) Aetna Health Exchange (AHE)	☐
Aetna Individual Lives (IVL)	☐
Value (VF)	☐

Formulary	Applies
New to Market (NTM)	☐
Standard Formulary Chart (SFC)	☑
Basic Control Chart Preferred Drug Plan Design (BCC PDPD)	☐
Advanced Control Specialty Formulary Chart (ACSFC)	☐
Value Formulary Chart (VFC)	☐
Medical Benefit	☐
Medical Benefit: Advanced Biosimilars First	☐
Medical Benefit: Managed Medicaid (MMMB)	☐
Medicare Part B	☐
Medicare Part B: Advanced Biosimilars First	☐

Exceptions Criteria
Human Immunodeficiency (HIV) Agents-Protease Inhibitors

This document informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

These criteria were developed to align with the following: Standard Formulary Chart (SFC).

Plan Design Summary

This program applies to the human immunodeficiency (HIV) protease inhibitor products specified in this document. Coverage for the targeted product is provided based on clinical circumstances that would exclude the use of the preferred products and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to all members requesting treatment with the targeted product.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

Table. HIV Protease Inhibitors

Medications considered formulary or preferred on your plan may still require a clinical prior authorization review.

	Product(s)
Preferred	• atazanavir (generic) • Evotaz (atazanavir and cobicistat) • Prezcobix (darunavir and cobicistat) • Prezista (darunavir)
Target	• Viracept (nelfinavir)

Exception Criteria

This document applies to members requesting treatment for an indication that is FDA-approved for the preferred product.

Coverage for Viracept is provided when the member meets any of the following criteria:

- Member is less than 3 years of age.
- Member is 3 years of age to less than 6 years of age or the member weighs less than 15 kg, and has a documented inadequate response, intolerable adverse event, or contraindication to Prezista.
- Member is 6 years of age or older and the member weighs 15 kg to less than 35 kg, and has a documented inadequate response, intolerable adverse event, or contraindication to both of the following:
    - atazanavir
    - Prezista
- Member is 6 years of age or older and the member weighs 35 kg to less than 40 kg, and has a documented inadequate response, intolerable adverse event, or contraindication to both of the following:
    - A preferred atazanavir product (atazanavir or Evotaz)
    - Prezista
- Member is 6 years of age or older and the member weighs at least 40 kg, and has a documented inadequate response, intolerable adverse event, or contraindication to both of the following:
    - A preferred atazanavir product (atazanavir or Evotaz)
    - A preferred darunavir product (Prezcobix or Prezista)

References

1. Atazanavir [package insert]. East Windsor, NJ: Aurobindo Pharma USA, Inc.; January 2024.
2. Evotaz [package insert]. Princeton, NJ: Bristol-Myers Squibb Company; May 2023.
3. Prezcobix [package insert]. Titusville, NJ: Janssen Therapeutics; March 2023.
4. Prezista [package insert]. Titusville, NJ: Janssen Therapeutics; March 2023.
5. Viracept [package insert]. Research Triangle Park, NC: ViiV Healthcare; March 2021.