

PRIOR AUTHORIZATION CRITERIA

CLASS NAME HIV UNBOOSTED THERAPY

BRAND NAME
(generic)

APTIVUS
(tipranavir)

INVIRASE
(saquinavir)

PREZISTA
(darunavir)

Status: CVS Caremark Criteria

Type: Post Step Therapy Prior Authorization

POLICY

PROGRAM DESCRIPTION

Plans implementing the HIV Unboosted Step Therapy (DUR) program will ensure that the patient's regimen includes a boosting agent. The adjudication system will look back for a boosting agent within the past 120 days. If the patient has filled a boosting agent within the past 120 days, then the requested drug will be paid under the prescription benefit. If the patient does not meet the initial look back, then the system will reject with a message ('Evaluate need for boosting drug') indicating that a prior authorization (PA) is required. The post DUR criteria would then be applied to requests submitted for evaluation to the PA unit.

INITIAL STEP THERAPY*

**Include Rx and OTC products unless otherwise stated.*

If the patient has filled a prescription for a boosting agent:

- Ritonavir
- Cobicistat
- Combination drugs containing cobicistat (e.g., Genvoya (elvitegravir-cobicistat-emtricitabine-tenofovir alafenamide), Stribild (cobicistat-elvitegravir-emtricitabine-tenofovir disoproxil))

within the past 120 days under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit. If the patient does not meet the initial step therapy criteria, then the claim will reject with a message indicating that a prior authorization (PA) is required. The post DUR criteria would then be applied to requests submitted for evaluation to the PA unit.

*Note: Some combination drugs containing ritonavir or cobicistat that are currently available (e.g., Kaletra (lopinavir/ritonavir), Evotaz (atazanavir/cobicistat), Prezcofix (darunavir/cobicistat), Symtuza (darunavir/cobicistat/emtricitabine/tenofovir alafenamide)) may be duplicative with the target drugs and/or are combination drugs containing a boosted Protease Inhibitor, therefore not included in the initial step therapy.

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

- The patient's regimen includes a boosting agent
[Note: Guidelines and product labeling recommend concurrent use of a boosting agent, such as ritonavir or cobicistat, or combination drugs that include boosting agents to improve virologic response to treatment.]

REFERENCES

1. Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. Available at <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>. Accessed November 2020.