BlueCross BlueShield of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

PHARMACY COVERAGE GUIDELINES
SECTION: DRUGS

ORIGINAL EFFECTIVE DATE: 4/1/19
LAST REVIEW DATE: 2/21/19
LAST CRITERIA REVISION DATE:
ARCHIVE DATE:

FUZEON® (enfuvirtide) subcutaneous injection

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the request form in its entirety with the chart notes as documentation. All requested data must be provided. Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. **Incomplete forms or forms without the chart notes will be returned.**

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Criteria:

- **Criteria for initial therapy:** Fuzeon (enfuvirtide) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

  1. Prescriber is a physician that specializes in HIV or Infectious Disease
  2. Individual is 6 years of age or older
  3. A confirmed diagnosis of HIV-1 infection in a treatment experienced individual with ongoing HIV-1 replication despite antiretroviral therapy
  4. Documentation of viral resistance to one agent in each of the following classes (as single agent products or combination products):
     - Non-nucleoside reverse transcriptase inhibitor (NNRTI) [See Definitions section]
     - Nucleoside reverse transcriptase inhibitor (NRTI) [See Definitions section]
     - Protease inhibitor (PI) [See Definitions section]
  5. Individual has failed at least 3 months of antiretroviral therapy, or is intolerant to, or has a contraindication such that the individual is unable to use antiretroviral therapy regimen consisting of three or more antiretroviral agents (see Definitions section)
  6. Will be used with an individualized background regimen of 3-5 antiretroviral agents selected on the basis of prior treatment history and baseline viral resistance measurements

  Initial approval duration: 12 months

- **Criteria for continuation of coverage (renewal request):** Fuzeon (enfuvirtide) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

  1. Individual continues to be seen by physician that specializes in HIV or Infectious Disease
  2. Individual's condition responded while on therapy
     - Response is defined as **BOTH** of the following:
       - Achieved and maintains reduced viral load or it is now undetectable
       - CD4 counts have improved
  3. Individual has been adherent with the medication
  4. Will be used with an individualized background regimen of 3-5 antiretroviral agents selected on the basis of prior treatment history and baseline viral resistance measurements
  5. Individual has not developed any contraindications or other significant level 4 adverse drug effects that may exclude continued use
     - Significant adverse effect such as:

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- Hypersensitivity to Fuzeon or any of its components

Renewal duration: 12 months

- Fuzeon (enfuvirtide) for all other indications not previously listed or if above criteria not met is considered ***experimental or investigational*** based upon:

1. Lack of final approval from the Food and Drug Administration, and
2. Insufficient scientific evidence to permit conclusions concerning the effect on health outcomes, and
3. Insufficient evidence to support improvement of the net health outcome, and
4. Insufficient evidence to support improvement of the net health outcome as much as, or more than, established alternatives, and
5. Insufficient evidence to support improvement outside the investigational setting.

These indications include, *but are not limited to*:
- Treatment with dosing or frequency outside the FDA-approved dosing and frequency

Description:

Fuzeon (enfuvirtide) is an HIV-1 fusion inhibitor indicated for use in combination with other antiretroviral agents for the treatment of HIV-1 infection in treatment experienced individuals with HIV-1 replication despite ongoing antiretroviral therapy.

HIV-1 clinical isolates resistant to nucleoside analogue reverse transcriptase inhibitors (NRTI), nonnucleoside analogue reverse transcriptase inhibitors (NNRTI), and protease inhibitors (PI) were susceptible to enfuvirtide in cell culture. Enfuvirtide has no activity against HIV-2.

Enfuvirtide exhibited additive to synergistic effects in cell culture assays when combined with individual members of various antiretroviral classes, including lamivudine, zidovudine, indinavir, nelfinavir, and efavirenz.

Definitions:

Failure of antiretroviral therapy:
A confirmed HIV ribonucleic acid (RNA) level of > 50 copies/mL while on therapy or intolerance due to drug toxicity

NNRTI: non-nucleoside reverse transcriptase inhibitors
Rescriptor (delavidine, DLV)
Sustiva (efavirenz, EFV)
Intelence (etravirine, ETR)
Edurant (rilpivirine, RPV)
Viramune Viramune XR® (nevirapine, NVP)

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NRTI: nucleoside reverse transcriptase inhibitors
- Ziagen (abacavir, ABC)
- Epzicom (abacavir + lamivudine)
- Trizivir (abacavir + lamivudine + zidovudine)
- Videx (didanosine [ddI])
- Emtriva (emtricitabine, FTC)
- Epivir (lamivudine, 3TC)
- Combivir (lamivudine+zidovudine)
- Zerit (stavudine, d4T)
- Hivid (zalcitabine, ddC)
- Retrovir (zidovudine, AZT or ZDV)

Protease inhibitors
- Reyataz (atazanavir, ATV)
- Prezista (darunavir, DRV)
- Lexiva (fosamprenavir, f-APV)
- Crixivan (indinavir)
- Viracept (nelfinavir, NFV)
- Norvir (ritonavir, RTV)
- Invirase (saquinavir, SQV)
- Aptivus (tipranavir, TPV)

Integrase inhibitors:
- Tivacay (dolutegravir, DTG)
- Vitekta (elvitegravir, EVG)
- Isentress, Isentress HD (raltegravir, RAL)

Cellular chemokine receptor (CCR5) antagonist:
- Selzentry (maraviroc, MVC)

Boosting agent:
- Tybost (cobicistat, COBI)

HIV combination products:
- Miscellaneous:
  - Triumeq (abacavir-dolutegravir-lamivudine) [NRTI+II+NRTI]?
  - Evotaz (atazanavir-cobicistat)
  - Biktary (bictegravir-emtricitabine-tenofovir alafenamide fumarate)
  - Prezcobix (darunavir-cobicistat)
  - Juluca (dolutegravir-rilpivirine)
  - Genvoya (elvitegravir-cobicistat-emtricitabine-tenofovir alafenamide fumarate)
  - Stribild (elvitegravir-cobicistat-emtricitabine-tenofovir disoproxil fumarate)
  - Kaletra (lopinavir + ritonavir, LPV/r)

Reverse transcriptase Inhibitor combinations:
- Epzicom (abacavir-lamivudine)
- Trizivir (abacavir-lamivudine-zidovudine)

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Atripla (efavirenz-emtricitabine-tenofovir disoproxil fumarate)
Symfi Lo (efavirenz-lamivudine-tenofovir disoproxil fumarate)
Odefsey (emtricitabine-rilpivrine-tenofovir alafenamide fumarate)
Complera (emtricitabine-rilpivrine-tenofovir disoproxil fumarate)
Descovy (emtricitabine-tenofovir alafenamide fumarate)
Truvada (emtricitabine-tenofovir disoproxil fumate)
Combivir (lamivudine-zidovudine)

Resources:

Fuzeon (enfuvirtide) product information accessed 12-20-18 at DailyMed: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=6935e846-d5a1-49e5-89a2-f8ebe4d5590d

UpToDate: Overview of antiretroviral agents to treat HIV. Current through Nov 2018. https://www-uptodate-com.mwu.idm.oclc.org/contents/overview-of-antiretroviral-agents-used-to-treat-hiv?topicRef=3773&source=see_link

UpToDate: Selecting an antiretroviral regimen for treatment-experienced HIV-infected patients who are failing therapy. Current through Nov 2018. https://www-uptodate-com.mwu.idm.oclc.org/contents/selecting-antiretroviral-regimens-for-the-treatment-naive-hiv-infected-patient?source=related_link

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Fax completed prior authorization request form to 602-864-3126 or email to pharmacyprecert@azblue.com.
Call 866-325-1794 to check the status of a request.
All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned.**
Pharmacy Coverage Guidelines are available at www.azblue.com/pharmacy.

Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.
REQUIRED: Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Member Information

Member Name (first & last):	Date of Birth:	Gender:	BCBSAZ ID#:
Address:	City:	State:	Zip Code:

Prescribing Provider Information

Provider Name (first & last):	Specialty:	NPI#:	DEA#:
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone:	Office Fax:	

Dispensing Pharmacy Information

Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information

Medication Name:	Strength:		Dosage Form:
Directions for Use:	Quantity:	Refills:	Duration of Therapy/Use:

☐ Check if requesting **brand** only ☐ Check if requesting **generic**

☐ Check if requesting continuation of therapy (prior authorization approved by BCBSAZ expired)

Turn-Around Time For Review

☐ Standard ☐ Urgent. Sign here: _____ ☐ Exigent (requires prescriber to include a written statement)

Clinical Information

1. **What is the diagnosis? Please specify below.**

   ICD-10 Code: _____ **Diagnosis Description:** _____

2. ☐ Yes ☐ No **Was this medication started on a recent hospital discharge or emergency room visit?**

3. ☐ Yes ☐ No **There is absence of ALL contraindications.**

4. **What medication(s) has the individual tried and failed for this diagnosis? Please specify below.**
Important note: Samples provided by the provider are not accepted as continuation of therapy or as an adequate trial and failure.

Medication Name, Strength, Frequency	Dates started and stopped or Approximate Duration	Describe response, reason for failure, or allergy

5. **Are there any supporting labs or test results? Please specify below.**

Date	Test	Value

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Pharmacy Prior Authorization Request Form

6. Is there any additional information the prescribing provider feels is important to this review? Please specify below.
For example, explain the negative impact on medical condition, safety issue, reason formulary agent is not suitable to a specific medical condition, expected adverse clinical outcome from use of formulary agent, or reason different dosage form or dose is needed.

Signature affirms that information given on this form is true and accurate and reflects office notes

Prescribing Provider's Signature: Date:

Please note: Some medications may require completion of a drug-specific request form.

Incomplete forms or forms without the chart notes will be returned.

Office notes, labs, and medical testing relevant to the request that show medical justification are required.