

Title: maraviroc (Selzentry)

Origination: 02/27/08	Revised: 09/07/11	Annual Review: 12/15/11
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Purpose:

To provide guidelines and criteria for the review and decision determination of requests for medications that requires prior authorization.

Background Information:

Medication Summary

- Selzentry (maraviroc) is a CCR5 co-receptor antagonist. Through this mechanism, it blocks entry of HIV into the host cell. It is indicated for combination anti-retroviral treatment of adults with detectable HIV-1 strains that have an affinity for the CCR5 co-receptor, have evidence of viral replication and HIV-1 strains resistant to multiple anti-retroviral agents.

Reference Statement

- Guidelines are compiled from available US Food and Drug Administration (FDA) approved indications, general practice guidelines, and/or evidence-based uses established through phase III clinical studies without published conflicting data. Only clinical studies published in their entirety in reputable peer-reviewed journals will be evaluated.

Eligibility Criteria

- Member must be eligible and have applicable benefit coverage.
- Prior authorization requests that do not meet clinical criteria in this Procedure will be forwarded to a Clinical Pharmacist for review.

Exclusion Criteria

- Members less than 16 years of age.

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Procedure:

- 1.0 Request for *initial therapy* with Selzentry for HIV treatment requires documentation from the Member's medical records maintained by the requesting independent practitioner verifying ALL of the following:
 - 1.1 Clinical documentation of HIV medications, including doses; **AND**
 - 1.2 Lab values indicating current CD4⁺ cell count and viral load; **AND**
 - 1.3 Lab assay (Tropism Assay) is provided verifying that Member has the CCR5 strain; **AND**
 - 1.4 If Member meets all of the criteria, may approve Selzentry for up to 12 months.
- 2.0 Request for *continuation of therapy* beyond initial authorization with Selzentry for HIV treatment requires documentation from the Member's medical records maintained by the requesting independent practitioner verifying of the following:
 - 2.1 Lab values showing an improvement in Member's CD4⁺ cell count and a decrease in Member's viral load; **AND**
 - 2.2 Member has shown adherence to provider appointments, and HIV regimens illustrated by reliable prescription refill history; **AND**
 - 2.3 If Member meets the above criteria, may approve for up to one (1) year.

References:

1. Selzentry, Pfizer Labs Inc., Full Prescribing Information, 2007.
2. Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Bethesda (MD): Department of Health and Human Services (DHHS); Jan 10,2011. Accessed 09/14/2011.



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Disclaimer Information:

Prior Authorization criteria are developed to determine coverage for AvMed Health Plans' benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. AvMed Health Plans makes coverage decisions based on the Member's benefit plan contract and these criteria. This guideline sets forth concise clinical coverage criteria which have been developed from a review of current literature, policies of the FDA and other government agencies, and other appropriate references, in consultation and with approval from practicing physicians who are members of AvMed's Pharmacy and Therapeutic committee. Treating providers are solely responsible for the medical advice and treatment of Members. This guideline may be updated and therefore is subject to change. The use of these criteria is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated.