UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2022 P 1092-10
Program	Prior Authorization/Notification
Medication	Selzentry® (maraviroc)
P&T Approval Date	1/2012, 2/2013, 11/2013, 2/2015, 2/2016, 2/2017, 2/2018, 2/2019, 2/2020, 2/2021, 1/2022
Effective Date	4/1/2022; Oxford only: 4/1/2022

1. Background:

Selzentry® (maraviroc) is a CCR5 co-receptor antagonist indicated in combination with other antiretroviral agents for the treatment *only* CCR5-tropic human immunodeficiency virus type 1 (HIV-1) infection in adults and pediatric patients weighing at least 2 kg. Selzentry is not recommended in patients with dual/mixed- or CXCR4-tropic HIV-1. Tropism testing with a highly sensitive tropism assay is required for the appropriate use of Selzentry. [1]

Members will be required to meet the coverage criteria below.

2. Coverage Criteria:

A. Selzentry

1. **Selzentry** will be approved based on **both** of the following criteria:

   a. Patient has CCR5-tropic HIV-1 infection as confirmed by a highly sensitive tropism assay

   -AND-

   b. Patient is currently taking or will be prescribed an optimized background antiretroviral therapy regimen

Authorization will be issued for 24 months.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Selzentry [Package Insert]. Research Triangle Park, NC: ViiV Healthcare; November 2021.

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Change Control	
11/2013	Annual Review - Removed reauthorization criteria. Clinical intent is to validate tropism assay testing at time of therapy initiation. Updated additional clinical rules. Updated references. Added change control table.
2/2015	Removed safety information in background section and added updated label language. Updated references.
2/2016	Annual review. Updated background section to reflect most current label. Removed reference to tropism testing from the DHHS treatment guidelines. Revised duration of authorization.
2/2017	Annual Review. Updated background information to reflect most current label. Updated reference.
2/2018	Annual review. No changes to coverage criteria.
12/2018	Administrative change to add statement regarding use of automated processes.
2/2019	Annual review. No changes to coverage criteria.
2/2020	Annual review. No changes to coverage criteria.
2/2021	Annual review. No changes to coverage criteria.
1/2022	Annual review with no changes to coverage criteria. Updated background and reference.