

**Tivicay (dolutegravir)  
Effective March 01, 2018**

<b>Plan</b>	<input checked="" type="checkbox"/> MassHealth <input type="checkbox"/> Commercial/Exchange	<b>Program Type</b>	<input type="checkbox"/> Prior Authorization <input checked="" type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
<b>Benefit</b>	<input checked="" type="checkbox"/> Pharmacy Benefit <input type="checkbox"/> Medical Benefit (NLX)		
<b>Specialty Limitations</b>	N/A		
<b>Contact Information</b>	<b>Specialty Medications</b>		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	<b>Non-Specialty Medications</b>		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	<b>Medical Specialty Medications (NLX)</b>		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
<b>Exceptions</b>	N/A		

**Overview**

N/A

**Coverage Guidelines**

Approval of Tivicay for quantities greater than 1 tablet daily, or 30 tablets per month, will be granted if the member meets the following criteria:

For members <18 years of age:

1. Member has a diagnosis of diagnosis of HIV-1 infection **AND**
2. Prescriber has provided documentation indicating Tivicay® is being used concomitantly with Sustiva® (efavirenz), Lexiva® (fosamprenavir)/Norvir® (ritonavir), Aptivus® (tipranavir)/Norvir® (ritonavir), Rifadin® (rifampin) or carbamazepine

For members ≥18 years of age:

1. Member has a diagnosis of diagnosis of HIV-1 infection **AND**
2. Prescriber has provided documentation of ONE of the following:
  - a. Tivicay® is being used concomitantly with Sustiva® (efavirenz), Lexiva® (fosamprenavir)/Norvir® (ritonavir), Aptivus® (tipranavir)/Norvir® (ritonavir), Rifadin® (rifampin) or carbamazepine
  - b. Integrase strand transfer inhibitor (INSTI)-associated resistance substitutions or clinically suspected INSTI-resistance (e.g., resistance to Isentress® or elvitegravir in Stribild®)

**Continuation of Therapy**

Reauthorization will require documentation of a positive response to therapy.



**Limitations**

1. Approvals will be granted for 12 months.
2. A maximum of 60 tablets per month will be approved after review.

**Appendix**

	<b>Dosing</b>	
<b>Tivicay</b>	<u>HIV-1 infection in INSTI-naïve adults and pediatric patients weighing at least 40 kg:</u> 50 mg once daily  <u>HIV-1 infection in INSTI-naïve adults and pediatric patients weighing at least 40 kg; coadministered with certain UGT1A or CYP3A inducers:</u> 50 mg twice daily  <u>HIV-1 infection in INSTI-experienced adults with certain INSTI-associated resistance substitutions or clinically suspected INSTI resistance:</u> 50 mg twice daily	<u>HIV-1 infection in INSTI-naïve pediatric patients weighing 30 kg to &lt;40 kg:</u> 35 mg once daily  <u>HIV-1 infection in INSTI-naïve pediatric patients weighing 30 kg to &lt;40 kg; coadministered with certain UGT1A or CYP3A inducers:</u> 35 mg twice daily

**References**

N/A

**Review History**

03/01/18 – Adopted MH RS

**Disclaimer**

AllWays Health Partners complies with applicable federal civil rights laws and does not discriminate or exclude people on the basis of race, color, national origin, age, disability, or sex.