**MEDICATION POLICY:**

# Atripla®

**Generic Name:** Efavirenz, Emtricitabine, Tenofovir Disoproxil Fumarate

**Therapeutic Class or Brand Name:** Atripla®

**Applicable Drugs (if Therapeutic Class):** N/A

**GPI Code:** 121099033003

**Preferred:** Symfi™, ®Symfi Lo™

**Non-preferred:** Atripla®

**Date of Origin:** 9/25/2018

**Date Last Reviewed / Revised:** N/A

## PRIOR AUTHORIZATION CRITERIA

(May be considered medically necessary when criteria I through III are met)

I. Documented diagnosis of HIV-1 infection.

II. Adult or pediatric patient weighing at least 40 kilograms.

III. Patient is unable to take Symfi™ and Symfi Lo™ due to documented history of intolerance or resistance to lamivudine (3TC).

## EXCLUSION CRITERIA

- History of hypersensitivity reaction (e.g., Stevens-Johnson syndrome, erythema multifo rme, or toxic skin eruptions) to efavirenz.
- Concurrent administration of voriconazole.
- Concurrent administration of elbasvir/grazoprevir.

## OTHER CRITERIA

- N/A

## QUANTITY / DAYS SUPPLY RESTRICTIONS

- Quantities of up to 30 tablets per 30 days.

## APPROVAL LENGTH

- **Authorization:** 1 year.
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing current medical necessity criteria are met and the medication is effective.

## APPENDIX

N/A

## REFERENCES

1. https://www.gilead.com/-/media/files/pdfs/medicines/hiv/atripla/atripla_pi.pdf?la=en .
2. https://pricerx.medispan.com/.
3. https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv-guidelines/0 .

## HISTORICAL TRACKING OF CHANGES MADE TO POLICY

| Date | Notes/Changes |
|---|---|
| | 1. |