UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2026 P 1092-14
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, 1/2023, 1/2024, 1/2025, 1/2026
Effective Date	4/1/2026

1. Background:

Selzentry® (maraviroc) is a CCR5 co-receptor antagonist indicated in combination with other antiretroviral agents for the treatment of 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.

Members will be required to meet the coverage criteria below.

2. Coverage Criteria[a]:

A. Authorization

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 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

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; September 2022.

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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.
1/2023	Annual review with no changes to coverage criteria. Added state mandate and updated references.
1/2024	Annual review. Revised duration of authorization.
1/2025	Annual review. Updated formatting without change to clinical intent.
1/2026	Annual review with no changes to coverage criteria.