This Coverage Policy applies to Individual Health Insurance Marketplace benefit plans only.

**Lamivudine/Zidovudine tablet**

**COVERAGE POLICY**

Combivir is covered for members who meet the following criteria:

1. Diagnosed HIV-1 infection
   
   **AND**
   
2. Documentation of previous combined use of individual agents
   
   - Epivir (lamivudine) and
   - Retrovir (zidovudine)

**AUTHORIZATION PERIOD AND LIMITATIONS**

*Initial Approval:* 3 years

**PROCUREMENT**

Specialty pharmacy source: Medco mail

**NON-COVERAGE**

Combivir is not covered for members with the following criteria:

A. Use not approved by the FDA; and

B. The use is unapproved and not supported by the literature or evidence as an accepted off-label use. (see Off-Label Use Policy for determining ‘accepted use’)

**REFERENCES**


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