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Drug Assistance Program (ADAP)

Authorization Form for SUNLENCA® (lenacapavir)

TELEPHONE: 888-311-7632 FAX: 800-848-4241 Ramsell

Prescriptions for Sunlenca® (lenacapavir) are only available with pre-approval. You can click on the name of the medication to be taken directly to the specific prescribing guidelines. If all the below requirements are met, the medication will be approved for 12 months from the initial request date.

NOTE: Sunlenca is only accessible via a Prior Authorization (PA) **ONLY** at ProCare Pharmacy Direct, LLC, (CVS SPECIALITY PHARMACY #2921) Monroeville.

To be eligible for this pre-approval, the following criteria must be met:

- Sunlenca® (lenacapavir) is being used in combination with other antiretrovirals (ARVs).
- Prescriber has confirmed status of client as a heavily treatment-experienced adult with multidrug resistant HIV-1 infection failing current ARV regimen due to resistance, intolerance, or safety considerations.
- Client has a current viral load greater than >200 copies per mL – results must be dated within the past 6 months and documentation must be provided.

First Name	Middle Initial	Last Name
Member ID	**Date of Birth**	

MEDICATION	STRENGTH	DOSE AND DIRECTIONS	QUANTITY / REFILLS
Sunlenca	☐ 300mg tablets ☐ 463.5mg/1.5ml vials	☐ **Loading dose Option 1** 927 mg by SQ injection (2 x 1.5ml injection) and 600 mg PO (2 x 300mg tablets) on Day 1 Then 600 mg orally (2 x 300 mg tablets) on Day 2	☐ **Loading dose 1** Quantity: 300 mg-4 tablet blister pack NDC 61958-3001-01 Injection dosing kit (contains 2 vials) NDC 61958-3002-01 Refills:
		☐ **Loading dose Option 2** 600 mg PO (2 x 300mg tablets) on Day 1 600 mg PO (2 x 300 mg tablets) on Day 2 300 mg PO (1 x 300mg tablet) on Day 8 Then 927 mg by SQ injection (2 x 1.5ml injections) on Day 15	☐ **Loading dose 2** Quantity: 300 mg-5 tablet blister pack NDC 61958-3001-01 Injection dosing kit (contains 2 vials) 61958-3002-01 Refills:
		☐ **Maintenance Dose** 927 mg by SQ injection (2 x 1.5ml injection) every 6 months (26 weeks) from the date of the last injection (+/- 2 weeks).	☐ **Maintenance** Quantity: Injection dosing kit (contains 2 vials) Refills: Ongoing Authorization

Most Current CD4 Count and Date	Most Recent Viral Load and Date (Provide copy of lab results)
Who will administer the SQ medication to client?	

Who will assume responsibility for medication upon shipment arrival?
Address where medication will be sent if approved?

Provider must acknowledge the following with initials:

_____ I have reviewed the prescribing guidelines for use, dosing, drug interactions and missed doses for this medication.

_____ Patient has been counseled on the high cost of treatment and is willing to be 100% adherent to treatment regimen.

Date: **To the best of my knowledge, I certify that the above is accurate and true and that this treatment is indicated, necessary and meets the guidelines for use.**		
Provider Name (Print)	Provider Signature	
Clinic Name:	Phone #	Fax #
Pharmacy Name *CVS SPECIALITY PHARMACY #2921) Monroeville.*	Pharmacy Phone #	Fax #
REQUIRED DOCUMENTATION - Please check off and submit lab reports noted below in reference to this request. Failure to provide documentation will delay decision process.		
☐ Recent HIV viral load >200 copies/mL (within the last 6 months)		

Submit: Please fax the completed application to Ramsell at **800-848-4241**.
For additional information, call the Ramsell Help Desk at: 1-888-311-7685.