

Prescriptions for [Sunlenca®](#) (lenacapavir) are only available with pre-approval through the Medication Assistance Program. You can click on the name of the medication to be taken directly to the specific prescribing guidelines. Physician or pharmacy will be notified if prior-authorization is approved.

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

- The patient is currently enrolled in MAP and eligible for MAP assistance.
- Sunlenca® (lenacapavir) is being used in combination with other antiretrovirals (ARVs).
- Prescriber has confirmed status of IL MAP client as a heavily treatment-experienced adult with multidrug resistant HIV-1 infection failing current ARV regimen due to resistance, intolerance, or safety considerations.
- MAP 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.

<b>First Name</b>	<b>Middle Initial</b>	<b>Last Name</b>
<b>Member ID</b>	<b>Date of Birth</b>	<b>RW ID (if known)</b>

MEDICATION	STRENGTH	DOSE AND DIRECTIONS	QUANTITY / REFILLS
Sunlenca	<input type="checkbox"/> 300mg tablets <input type="checkbox"/> 463.5mg/1.5ml vials	<input type="checkbox"/> <b>Loading dose Option 1</b> 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	<input type="checkbox"/> <b>Loading dose 1</b> Quantity: 300 mg-4 tablet blister pack NDC 61958-3001-01 Injection dosing kit (contains 2 vials) NDC 61958-3002-01  Refills: <u>0</u>
		<input type="checkbox"/> <b>Loading dose Option 2</b> 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	<input type="checkbox"/> <b>Loading dose 2</b> Quantity: 300 mg-5 tablet blister pack NDC 61958-3001-01 Injection dosing kit (contains 2 vials) 61958-3002-01  Refills: <u>0</u>
		<input type="checkbox"/> <b>Maintenance Dose</b> 927 mg by SQ injection (2 x 1.5ml injection) every 6 months (26 weeks) from the date of the last injection (+/- 2 weeks).	<input type="checkbox"/> <b>Maintenance</b> Quantity: Injection dosing kit (contains 2 vials)  Refills: <u>Ongoing Authorization</u>

<b>Most Current CD4 Count and Date</b>	<b>Most Recent Viral Load and Date (Provide copy of lab results)</b>
<b>Who will administer the SQ medication to client?</b>	
<b>Who will assume responsibility for medication upon shipment arrival?</b>	

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: \_\_\_\_\_

<b>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.</b>
Provider Name (Print) _____ Provider Signature _____
Clinic Name: _____ Phone # _____ Fax # _____
Pharmacy Name _____ Pharmacy Phone # _____ Fax # _____
<b>REQUIRED DOCUMENTATION - Please check off and submit lab reports noted below in reference to this request. Failure to provide documentation will delay decision process.</b>
<input type="checkbox"/> Recent HIV viral load >200 copies/mL (within the last 6 months)

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