**Sunlenca (lenacapavir) Prior Authorization Form**

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| --- | --- |
| **Client name:** Click here to enter text. | |
| **Date of birth:** Click here to enter text. | **ADAP ID#:** Click here to enter text. |

**Is this a**  **new med start, or**  **continuation of therapy?**

**If this is a new start, indicate the proposed Sunlenca dose below:**

2-day initiation: 600mg orally once daily on days 1 & 2, & 927mg subcutaneously on day 1; followed by 927mg SQ every 6 months (26 weeks) from date of last injection, **OR**

15-day initiation: 600mg orally once daily on days 1 & 2, 300mg orally once on day 8, then 927mg subcutaneously on day 15; followed by 927mg SQ every 6 months (26 weeks) from date of last injection

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| --- | --- | --- |
| Does client have a history of treatment failure? | Yes | No |
| Is the client on an optimized oral antiretroviral regimen? | Yes | No |
| **List proposed optimized antiretroviral regimen:** Click here to enter text. |  |  |
| Does client plan to become pregnant? | Yes | No |
| Is client able to attend regularly scheduled appointments? | Yes | No |
| Sunlenca is a major CYP3A4 substrate and moderate inhibitor that can potentiate many drug interactions. It is **contraindicated** with CYP3A inducers. The patient’s med list has been reviewed & any potential interactions have been addressed. | Yes | No |
| Have you confirmed that the primary insurance plan will cover Sunlenca? | Yes | No |
| Have you confirmed that client can obtain Sunlenca from CVS Specialty? | Yes | No |

Please document mutations here: Click here to enter text.

**\*\*You must submit the following: documentation of all other antiretroviral regimens tried, documentation of entire Prior Auth process & outcome, genotype results & any additional information relevant to this request.**

Provide 3 most recent HIV RNA results:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date:  Click to enter a date. | HIV RNA: Click here to enter text. | Date:  Click to enter a date. | HIV RNA: Click here to enter text. | Date:  Click to enter a date. | HIV RNA:  Click here to enter text. |

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| --- | --- | --- |
| Date:Click here to enter text.To the best of my knowledge, I certify that the above information is accurate and true. | | |
| Prescriber Signature: | | |
| Prescriber Name: Click here to enter text. | NPI: Click here to enter text. | |
| Phone #: Click here to enter text. | | Fax #:Click here to enter text. |

**Please fax completed form to (302) 320-1373 for review. This request will be reviewed, then a determination will be provided within 5 business days from the date of submission.**