
	<p><b>Delaware Health &amp; Social Services</b>  <b>Division of Public Health</b>  <b>Ryan White ADAP Program</b>  <b>Phone: 302-744-1050</b>  <b>Fax: 302-661-7226</b></p>	
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### Sunlenca (lenacapavir) Prior Authorization Form

<b>Client name:</b> <a href="#">Click here to enter text.</a>		
<b>Date of birth:</b> <a href="#">Click here to enter text.</a>	<b>ADAP ID#:</b> <a href="#">Click here to enter text.</a>	

**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

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

<b>Date:</b> <a href="#">Click to enter a date.</a>	<b>HIV RNA:</b> <a href="#">Click here to enter text.</a>	<b>Date:</b> <a href="#">Click to enter a date.</a>	<b>HIV RNA:</b> <a href="#">Click here to enter text.</a>	<b>Date:</b> <a href="#">Click to enter a date.</a>	<b>HIV RNA:</b> <a href="#">Click here to enter text.</a>
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<b>Date:</b> <a href="#">Click here to enter text.</a> To the best of my knowledge, I certify that the above information is accurate and true.	
<b>Prescriber Signature:</b>	
<b>Prescriber Name:</b> <a href="#">Click here to enter text.</a>	<b>NPI:</b> <a href="#">Click here to enter text.</a>
<b>Phone #:</b> <a href="#">Click here to enter text.</a>	<b>Fax #:</b> <a href="#">Click here to enter text.</a>

**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.**

**For office use only:**

<b>Clinical review completed by:</b>		<b>Date:</b>
<b>Outcome:</b>	Approved	Denied
<b>ADAP review completed by:</b>		<b>Date:</b>
<b>Outcome:</b>	Approved	Denied