AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Sunlenca® (lenacapavir) **(Pharmacy)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Maintenance Dose: 927 mg by subcutaneous injection (2 x 1.5 mL injections) every 6 months (26 weeks) from the date of the last injection +/- 2 weeks

Quantity Limit: 3 mL per 184 days

Provider please note: Upon approval of Sunlenca® maintenance subcutaneous injection, a subsequent authorization will be entered under the pharmacy benefit to allow a one-time fill of Sunlenca® tablets for induction dosing.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member is ≥ 12 years of age and weighing ≥ 35 kg, or an adult aged ≥ 18 years
- ❑ Prescribed by, or in consultation with, an infectious disease specialist or specialist in HIV treatment

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- ❑ Member has been identified to have multidrug resistant HIV-1 infection with documented resistance to at least **TWO (2)** antiretroviral medications from **≥ 3 of the 4 main** antiretroviral drug classes below **(must submit genotype/phenotype resistance testing results)**:
  - ❑ Nucleoside Reverse Transcriptase Inhibitors/Non-nucleoside Reverse Transcriptase Inhibitors
  - ❑ Protease Inhibitors
  - ❑ Entry Inhibitors (including CCR5 antagonists)
  - ❑ Integrase Inhibitor
- ❑ Member is experiencing current virologic failure defined as having a viral load greater than 400 copies/mL before treatment initiation
- ❑ Member's current viral load has been submitted with request
  - Current Viral Load: _____ copies/mL **(must submit most recent labwork indicating viral load prior to initiating therapy, within 4-8 weeks)**
- ❑ Provider confirms requested medication will be used in conjunction with an optimized background regimen for antiretroviral therapy
- ❑ Provider confirms requested medication will be initiated using **ONE** of the following dosing regimens:

❑ **Initiation Option 1**	
Day 1	927 mg by subcutaneous injection (2 x 1.5 mL injections) **AND** 600 mg orally (2 x 300 mg tablets)
Day 2	600 mg orally (2 x 300 mg tablets)
❑ **Initiation Option 2**	
Day 1	600 mg orally (2 x 300 mg tablets)
Day 2	600 mg orally (2 x 300 mg tablets)
Day 8	300 mg orally (1 x 300 mg tablet)
Day 15	927 mg by subcutaneous injection (2 x 1.5 mL injections)

Medication being provided by Specialty Pharmacy – Proprium Rx

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: 3/17/2023
REVISED/UPDATED: ~~4/7/2023,~~ **1/13/2026**