

SENTARA HEALTH PLANS

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 1-800-750-9692.** 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 Sentara #: _____ 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:

<input type="checkbox"/> 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)
<input type="checkbox"/> 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
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*****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.****