UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Sunlenca (lenacapavir)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: *All of the following criteria must be met)*

- ❑ 18 years of age or older.
- ❑ Prescribed by or in consultation with an infectious disease specialist.
- ❑ Prescriber will manage planned and unplanned missed doses per the prescribing information.
- ❑ Sunlenca will be used concomitantly with other fully active antiretroviral(s) indicated for the treatment of HIV-1 infection. Medication(s): _____ Chart note page #: _____
- ❑ Resistance, intolerance, or contraindication to **at least 2 antiretroviral therapies from each of at least 3 of the below 4 classes** of antiretroviral medications, including:

Medication/Dose	Details of Failure	Chart Note Pg #
Nucleoside Reverse-Transcriptase Inhibitor (NRTI) Medication:		
Non-Nucleoside Reverse Transcriptase Inhibitor (NNRTI) Medication:		
Protease inhibitor (PI) Medication:		
Integrase Strand Transfer Inhibitor Medication:		

Requested doses: Medicaid approves specific doses and quantities of medications. Please indicate specific dose:

<table>
<tr><td colspan="2">❑ Initiation Option 1</td><td colspan="2">❑ Initiation Option 2</td></tr>
<tr><td rowspan="2">Day 1</td><td rowspan="2">927 mg by subcutaneous injection (2 x 1.5 mL injections) AND
600 mg orally (2 x 300 mg tablets)</td><td>Day 1</td><td>600 mg orally (2 x 300 mg tablets)</td></tr>
<tr><td>Day 2</td><td>600 mg orally (2 x 300 mg tablets)</td></tr>
<tr><td rowspan="2">Day 2</td><td rowspan="2">600 mg orally (2 x 300 mg tablets)</td><td>Day 8</td><td>300 mg orally (1 x 300 mg tablet)</td></tr>
<tr><td>Day 15</td><td>927 mg by subcutaneous injection (2 x 1.5 mL injections)</td></tr>
<tr><td colspan="4">❑ Maintenance</td></tr>
<tr><td colspan="2">Every 6 months (26 weeks) +/-2 weeks</td><td colspan="2">927 mg by subcutaneous injection (2 x 1.5 mL injections)</td></tr>
</table>

Re-authorization Criteria:
Updated letter with medical justification or updated chart notes demonstrating positive clinical response.

Initial Authorization: Up to six (6) months
Re-authorization: Up to one (1) year

Note:

Use appropriate HCPCS code for billing
Coverage and Reimbursement code look up: https://health.utah.gov/stplan/lookup/CoverageLookup.php
HCPCS NDC Crosswalk: https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date