Sunlenca (Lenacapavir sodium tablets)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL**		**IF RENEWAL:** DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

Revision Date: 08/01/2023

Prime THERAPEUTICS™

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ HIV-1 infection ☐ Other diagnosis: _____ICD-10:_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Will Sunlenca be used as part of a clinical trial? ☐ Yes ☐ No

Is the patient heavily treatment experienced with multidrug resistant HIV-1 infection? ☐ Yes ☐ No

Does the patient have documented resistance to > 2 antiretroviral (ARV) medications from each of > 3 of the 4 main classes of HIV medication treatment? ☐ Yes ☐ No *Please submit documentation*.

Does patient have documented resistance to 2 nucleoside reverse-transcriptase [NRTIs]? ☐ Yes ☐ No *Please submit documentation*.

Does patient have documented resistance to 2 nonnucleoside reverse-transcriptase inhibitors [NNRTIs]? ☐ Yes ☐ No *Please submit documentation*.

Does patient have documented resistance to 2 protease inhibitors [PIs]? ☐ Yes ☐ No *Please submit documentation*.

Does patient have documented resistance to 2 integrase strand-transfer inhibitors [INSTI])? ☐ Yes ☐ No *Please submit documentation*.

Does the patient have at least 2 fully active ARV drugs remaining from the 4 main classes that can be effectively combined? ☐ Yes ☐ No *Please submit documentation*.

Does patient have an HIV-1 RNA level of ≥400 copies per milliliter? ☐ Yes ☐ No *Please submit documentation*.

Does the patient have a history of treatment failure or known or suspected resistance to lenacapavir? ☐ Yes ☐ No *Please submit documentation.*

Will the tablets be used for oral induction with Sunlenca (lenacapavir)? ☐ Yes ☐ No

Will Sunlenca (lenacapavir) be used with other antiretrovirals (optimized background regimen)? ☐ Yes ☐ No *Please submit documentation.*

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811