REALRx

PRIOR AUTHORIZATION REQUEST FORM

HEAVILY TREATED HIV

Rukobia™, Sunlenca®

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested:

1. Preferred:
   a. Sunlenca® (lenacapavir)
2. Non-Preferred:
   a. Rukobia™ (fostemsavir): Clinical documentation must show trial and failure of Sunlenca or medical necessity for oral administration
3. Non-Covered:
   a. Trogarzo® (ibalizumab-uiyk): Clinical documentation must show trial and failure of Sunlenca and Rukobia

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
2. Is the member diagnosed with multidrug resistant HIV-1 infection?	☐	☐	**Please provide documentation**
3. Is the requesting provider an HIV or infectious disease specialist, or in consultation with one?	☐	☐	
4. Is the member is currently failing an antiretroviral drug regimen for the treatment of HIV-1?	☐	☐	**Please provide documentation**
5. Is the member is adherent to antiretroviral regimen(s)?	☐	☐	**Please provide documentation**
6. Has the member has tried and failed at least three (3) of the following antiretroviral classes (failure is demonstrated by	☐	☐	**Please provide documentation**

current or projected HIV resistance to all agent(s) within each class, or clinically significant adverse effects/contraindications to all agent(s) within each class)? • Nucleoside reverse transcriptase inhibitors (NRTI) (e.g, abacavir, didanosine, emtricitabine, lamivudine, stavudine, tenofovir disoproxil fumarate, tenofovir alafenamide, zidovudine) • Non-nucleoside reverse transcriptase inhibitors (NNRTI) (e.g., delaviridine, efavirenz, etravirine, nevirapine, nevirapine XR, rilpivirine) • Protease inhibitors (PI) (e.g., atazanavir, darunavir, fosamprenavir, indinavir, nelfinavir, ritonavir, saquinavir, tipranavir) • Integrase inhibitors (e.g., raltegravir, dolutegravir, elvitegravir) • CCR5-antagonists (e.g., Selzentry® (maraviroc))			
7. Will the requested drug be used in combination with optimized background antiretroviral regimen(s)?	☐	☐	**Please provide documentation**
8. Does the member have a plasma HIV RNA viral load ≥ 400 copies/mL?	☐	☐	**Please provide documentation**
9. Does the member have a documented CD4 count within the past 30 days?	☐	☐	**Please provide documentation**
10. For Rukobia™, does clinical documentation show trial and failure of Sunlenca®, or medical necessity for oral administration?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does the member show a positive clinical response to therapy evidenced by a reduction of HIV RNA viral load and an increased CD4 count?	☐	☐	**Please provide documentation**
3. Is the member adherent to the HIV regimen and optimized background antiretroviral regimen(s)?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			

Physician Signature:

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Policy: PHARM-149
Origination Date: 03/09/2023
Reviewed/Revised Date: 03/15/2023
Next Review Date: 03/15/2024
Current Effective Date: 04/01/2023