

## PRIOR AUTHORIZATION REQUEST FORM

### Sunlenca

For authorization, please answer each question and fax this form PLUS chart notes back to RealRx Medicaid Prior Authorization Department 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 Pharmacy Customer Service for assistance.

- Healthy U: 855-856-5694
- Healthy U CHIP: 855-203-3633
- Health Choice Utah: 855-864-1404

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:

Product Requested:  Sunlenca (lenacapavir)

Requested Doses: Medicaid approves specific doses and quantities, select the dose that applies to the patient.

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 tablets)

Day 15: 927 mg by subcutaneous injection (2 x 1.5 mL injections)

Maintenance

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

Criteria for Approval (ALL of the following criteria must be met):	Yes	No
1. Is the patient 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the patient have HIV-1 infection?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the medication being prescribed by or in consultation with an HIV specialist or a provider specializing in the treatment of infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>
4. Will the prescriber manage planned and unplanned missed doses per the prescribing information?	<input type="checkbox"/>	<input type="checkbox"/>
5. Will Sunlenca be used concomitantly with other fully active antiretrovirals(s) indicated for the treatment of HIV-1 infections?  Medication(s): _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the provider attest that the patient is NOT taking strong or moderate CYP3A inducers, and/or combination of UGT1A, and strong CYP3A inhibitors concomitantly, which may significantly affect lenacapavir plasma concentration, resulting in a loss of virologic response or increase in side effects?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the patient have resistance, intolerance, or contraindication to at least 2 different combinations of guideline-recommended initial treatments with 2 NRTIs plus (a) INSTI, (b) Boosted PI, or (c) NNRTI?	<input type="checkbox"/>	<input type="checkbox"/>

Drug/Dose: _____ Details of Failure: _____		
Drug/Dose: _____ Details of Failure: _____		
<b>Reauthorization</b>		
1. Has the provider submitted an updated letter with medical justification or updated chart notes demonstrating maintenance of virological suppression with HIV-1 RNA less than <200 copies/ml?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is Sunlenca being used concomitantly with other antiretroviral(s) indicated for the treatment of HIV-1 infection?  Medication(s): _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>PRESCRIBER CERTIFICATION</b>		
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.		
Physician's Signature:	Date:	

**Initial Authorization:** Up to six (6) months

**Reauthorization:** Up to one (1) year

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

Policy: PHARM-HYB-188  
 Origination Date: 01/01/2026  
 Reviewed/Revised Date:  
 Next Review Date:  
 Current Effective Date: 01/01/2026

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