Lenacapavir Prior Authorization Form

Instructions:

- Fax completed form and documentation to ADAP confidential fax line at 850-412-2680.
- For any questions regarding this form, please contact the HIV Medical Team at HIVMedicalTeam@flhealth.gov.

Note: Prescriber will receive a written response via fax within three business days.

PATIENT LAST NAME:	**PATIENT FIRST NAME:**	**DATE OF BIRTH:** / /
PRESCRIBER NAME (first and last):		
CREDENTIALS: ☐ **APRN**	☐ **DO** ☐ **MD**	☐ **PA**
PRESCRIBER PHONE:	**PRESCRIBER FAX:**	
PRESCRIBER EMAIL:		
OFFICE CONTACT NAME /NUMBER:		

COVERAGE FOR INSURED CLIENTS ONLY ***Select <u>one</u> of the options below.***	
☐	Patient's insurance will be the primary payor and ADAP will cover copay only • Submission of this form is not required. • **You will be contacted to provide information, if needed, befo*re a coverage determination is made.***
☐	Patient's insurance has denied coverage and ADAP will be the sole payor • Submit documentation of insurance denial for lenacapavir • **Complete remainder of this form and submit completed form and documentation as instructed above.**

- **Important Notes:**
  - Florida ADAP may need to implement a patient cap
  - If request is for continuation of therapy, complete patient and provider information on the top of the form and proceed to page 3
  - Lenacapavir approval will be provided for a maximum of 1 year
  - Provider is responsible for the care and assessment of the patient
  - Provider should obtain an HIV VL 4-8 weeks after starting the lenacapavir-containing regimen and then every 3-4 months or as clinically indicated

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LENACAPAVIR (SUNLENCA) CRITERIA FOR USE

- **Patient must meet all criteria listed below to receive lenacapavir through Florida ADAP.**
- **If the patient does not meet one or more of these criteria, please submit a written explanation for the rationale for requesting lenacapavir for your patient. These requests will be considered on a case-by-case basis.**

Select all that apply:

☐	Adult (≥ 18 years old) with HIV-1 infection
☐	Receiving a stable failing regimen for ≥ 8 weeks with most recent (within 8 weeks of PA request) HIV-1 viral load ≥ 400 copies/mL • Drugs included in the failing regimen: • Start date of failing regimen: _____
☐	Documented resistance to ≥ 2 medications from ≥ 3 of the following 4 classes of antiretrovirals (ARVs): NRTI, NNRTI, PI, INSTI (Attach all current and prior resistance test results)
☐	Document ≤ 2 fully active ARVs from the NRTI, NNRTI, PI, and INSTI classes due to resistance, intolerance, or safety concerns. (Submit all current and prior resistance test results and documentation of allergies, intolerances, drug access or safety concerns)
☐	≥ 1 fully active agent available to use with lenacapavir. List other antiretrovirals that will be used with lenacapavir:
☐	Patient is not on any concomitant medications that are contraindicated or not recommended for use with lenacapavir (see Sunlenca prescribing information at https://www.gilead.com/-/media/files/pdfs/medicines/hiv/sunlenca/sunlenca_pi.pdf for details) List all other medications the patient is taking:

NRTI = nucleoside reverse transcriptase inhibitor, NNRTI = non-nucleoside reverse transcriptase inhibitors, PI = protease inhibitor, INSTI = integrase strand transfer inhibitor

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Authorizations will be approved for 12 months, providing patient remains virally suppressed. For requests for continuation of therapy, provide the following information:

- Start date of lenacapavir: _____
  - If patient was getting lenacapavir coverage through another source besides Florida ADAP, please indicate, how patient was getting (e.g., private insurance, Medicaid, etc.):

- Other antiretrovirals the patient is taking with lenacapavir:

- HIV-1 VL result within 8-12 weeks of request for continuation of lenacapavir. If VL is not suppressed to < 200 copies/mL, provide HIV-1 VL and CD4 count results since the start of lenacapavir.

☐ **I agree to submit HIV-1 viral load and/or CD4 counts when requested.** ☐ **I understand that ADAP may rescind the approval for lenacapavir (with prior provider notice) for any reason [e.g., patient is not responding adequately (e.g., rising viral load while on therapy), patient is not adherent, fiscal constraints].**

PRESCRIBER SIGNATURE:		**Date:**	**/ /**
ADAP USE ONLY			
CLIENT ID NUMBER:		**Date Request Received:**	**/ /**
Request Approved:	☐ Yes ☐ No	**Reviewed by:**	