# Human Immunodeficiency Virus (HIV) Step Therapy

**Sunlenca (Lenacapavir) J1961 is non-preferred.**
**The preferred products are Medicare Part D HIV Therapies:**
**Included, but not limited to: Tenofovir, Ritonovir, etc.**
**(no PA required for most preferred Part D alts)**
**Prior Authorization Step Therapy**
**Medicare Part B Request Form**

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

| ☐ | **Standard Request– (72 Hours)** | ☐ | **Urgent Request** (standard time frame could place the member's life, health or ability in serious jeopardy) |
|---|---|---|---|
| | Date Requested ________________ | | |
| | Requestor ________________ Clinic name: ________________ Phone / Fax | | |

**MEMBER INFORMATION**

*Name:______________________________ *ID#:________________ *DOB:________________

**PRESCRIBER INFORMATION**

*Name:____________________________ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:________________

*Address:__________________________________________________ *Fax:________________

**DISPENSING PROVIDER / ADMINISTRATION INFORMATION**

*Name:_____________________________ Phone:______________________

*Address:______________________________________________ Fax:______________________

**PROCEDURE / PRODUCT INFORMATION**

| HCPC Code | Name of Drug | Dose (Wt: _____ kg Ht:______ ) | Frequency | End Date if known |
|---|---|---|---|---|
| | | | | |

☐ **Self-administered** ☐ **Provider-administered** ☐ **Home Infusion**

☐Chart notes attached. **Other important information:**________________________________________

**Diagnosis: ICD10**: ________ **Description**: ______________________________________

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

**CLINICAL INFORMATION**

☐ **New Start or Initial Request: (Clinical documentation required for all requests)**

☐ Being used to treat human immunodeficiency virus (HIV) infection.

☐ Being used in combination with other antiretroviral agents:
List Agents: ____________________________________________________________

☐ Patient is heavily antiretroviral treatment experienced with resistance, intolerability or contraindication to antiretrovirals in at least three different classes (NRTI, NNRTI, PI or INSTI);

☐ Patient is failing their current antiretroviral regimen due to resistance, intolerance or safety considerations.

☐ Patient has a viral load greater than or equal to 400 copies/mL.

☐ **Continuation Requests: (Clinical documentation required for all requests)**

☐ Patient had an adequate response or significant improvement while on this medication.
If not, please provide clinical rationale for continuing this medication: ______________________________
________________________________________________________________________________

**ACKNOWLEDGEMENT**

**Request By (Signature Required): ________________________________________Date:_____ /____ /____**

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.** PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

## Prior Authorization Group – HIV Step Therapy

**Drug Name(s):**
**SUNLENCA** **LENACAPAVIR**

**Criteria for approval of Non-Formulary/Preferred Drug:**

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Member has tried and failed at least ONE formulary Part D Human Immunodeficiency Virus treatment regimen (See www.atriohp.com for all formulary Part D treatment options for HIV) OR
   - There is clinical documentation stating preferred formulary alternatives are contraindicated.
3. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

**Exclusion Criteria:**
**N/A**

**Prescriber Restrictions:**
**N/A**

**Coverage Duration:**
**Approval will be for 12 months**

**FDA Indications:**
**Sunlenca**

- HIV infection, Heavily treatment-experienced with multidrug resistant HIV-1 infection and failing current antiretroviral regimen

**Off-Label Uses:**
**N/A**

**Step Therapy Drug(s) and FDA Indications:**
**Assorted HIV Treatment Options**:

- HIV infection, in combination with other antiretroviral agents
- HIV infection, Preexposure, in at-risk patients and excluding patients at risk from receptive vaginal sex; Prophylaxi

**Age Restrictions:**
N/A

**Other Clinical Consideration:**
N/A

**Resources:**
https://www.micromedexsolutions.com/micromedex2/librarian/PFDefaultActionId/evidencexpert.DoIntegratedSearch?navitem=headerLogout#

CLINICAL / CMS ONLY