Sunlenca
(lenacapavir) VIALS

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462 (800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician's Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Sunlenca vial ICD10:

Directions for use: Dose and Quantity: Duration of Therapy:

J-code:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

*****Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Option Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is your patient a candidate for home infusion? ☐ Yes ☐ No

Does the physician have an in-office infusion site? ☐ Yes ☐ No

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:

☐ Human Immunodeficiency Virus (HIV)-1 Infection, Treatment
☐ Pre-Exposure Prophylaxis (PrEP) of Human Immunodeficiency Virus (HIV)
☐ Other (please specify):

Clinical Information:

Is this initial therapy or is the patient currently receiving Sunlenca? If patient has been taking samples, please pick "initial therapy."
☐ Initial Therapy
☐ Currently Receiving Sunlenca

(if initial therapy) Will the requested medication be taken in combination with an optimized antiviral background regimen including one or more other antiretroviral agents? ☐ Yes ☐ No

(if initial therapy) Is this medication prescribed by, or in consultation with, a physician who specializes in the treatment of HIV infection? ☐ Yes ☐ No

(if initial therapy) Is the patient failing a current antiretroviral regimen for HIV, according to the prescriber? ☐ Yes ☐ No

(if initial therapy) The covered alternatives are TWO or more agents from at least THREE of the following antiviral classes (a, b, c, d); (A) Nucleoside reverse transcriptase inhibitor. Note: Examples of nucleoside reverse transcriptase inhibitors include abacavir, didanosine, emtricitabine, lamivudine, stavudine, tenofovir disoproxil fumarate, tenofovir alafenamide, zidovudine; (B) Non-nucleoside reverse transcriptase inhibitor. Note: Examples of non-nucleoside reverse transcriptase inhibitors include delaviridine, efavirenz, etravirine, nevirapine, nevirapine XR, rilpivirine; (C) Protease inhibitor. Note: Examples of protease inhibitors include atazanavir, darunavir, fosamprenavir, indinavir, nelfinavir, ritonavir, saquinavir, tipranavir; (D) Integrase strand transfer inhibitor. Note: Examples of integrase strand transfer inhibitors include raltegravir, dolutegravir, elvitegravir. For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced.

(if initial therapy) Does the patient have resistance to two or more agents from at least THREE of the antiviral classes listed above? ☐ Yes ☐ No

(if currently receiving) Has the patient responded to a Sunlenca-containing regimen? Note: Examples of a response are HIV RNA less than 50 cells/mm3, HIV-1 RNA at least 0.5 log10 reduction from baseline in viral load, improvement or stabilization of CD4 T-cell count. ☐ Yes ☐ No

(if no) Please provide support for continued use.

(if currently receiving) Will the requested medication continue to be taken in combination with an optimized antiviral background regimen including one or more other antiretroviral agents? ☐ Yes ☐ No

Additional Information: *(including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer 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:_____ **Date:**_____

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005