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 463.5mg/1.5mL solution for injection ICD10:

Dose and Quantity: Duration of therapy: Frequency of administration:

J-code:

Is this a new start or continuation of therapy? If your patient has already begun treatment with samples, please choose "new start of therapy". ☐ new start of therapy ☐ continuation of therapy

(if continuation of therapy) Is there documentation of a beneficial response to this medication? Yes ☐ No ☐

(if no) Please provide support for continued use.

Where will this medication be obtained?
☐ Walgreen's
☐ Prescriber's office stock (billing on a medical claim form)
☐ Home Health / Home Infusion vendor
☐ Other (please specify):

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):
NOTE: *Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting*

Is this infusion occurring in a facility affiliated with hospital outpatient setting? ☐ Yes ☐ No

If yes- Is this patient a candidate for re-direction to an alternate setting after 1-2 infusions (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

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

Clinical Information:

How is this medication being used?
☐ As Pre-Exposure Prophylaxis (PrEP) of Human Immunodeficiency Virus (HIV)
☐ Treatment of Human Immunodeficiency Virus (HIV)
☐ Other

(if other) What is the diagnosis related to use of this medication?

(if treatment) Has the patient received any type of treatment for this disease before? ☐ Yes ☐ No

(if previous treatment) Does the patient have history of multi-drug resistant disease? ☐ Yes ☐ No

(if previous treatment) Will this medication be taken in combination with other antiviral agents? ☐ Yes ☐ No

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

Additional Information: *Please provide clinical rationale for the use of this drug for your patient (pertinent patient history, alternatives tried, any inability to use alternatives above or standard therapy, etc). Please include drug name(s), 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*

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:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

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