MISSISSIPPI STATE DEPARTMENT OF HEALTH

PROVIDER ATTESTATION FORM

For Patients Receiving SUNLENCA® through Mississippi ADAP

The Mississippi AIDS Drug Assistance Program (ADAP) requires that all providers who prescribe Sunlenca to patients at the Mississippi State Department of Health Pharmacy (MSDH) complete an attestation form to certify that patients meet the criteria for eligibility.

INSTRUCTIONS: This attestation form is to be completed, signed, and dated by the prescriber. Please fax form to MSDH Pharmacy at (601)-364-2670 once complete. Sunlenca cannot be dispensed from MSDH Pharmacy until this form is completed and submitted to the Mississippi ADAP.

DEMOGRAPHIC INFORMATION		
Client Name:		
Date of Birth:	Phone:	
Street Address:		
City:	State:	Zip:
Provider Information		
Provider Name:	Provider NPI:	
Name of Clinic:	Phone:	
Clinic Street Address:		
City:	State:	Zip:

ATTESTATION *Mark each criterion with an "X"*	
	Provider has submitted laboratory results to CAREWare or MSDH Pharmacy showing that the patient's current therapy is failing. (Labs must be collected with three months of the initiation of Sunlenca.)
	Patient has no prior virologic failures or baseline resistance to Sunlenca.
	Patient was informed of the risks of missed doses of Sunlenca.
	Patient will receive concomitant optimized background therapy (OBT) while taking Sunlenca.
PROVIDER SIGNATURE:	**DATE:**

NO STAMPS OR REPRESENTATIVE SIGNATURE ACCEPTED

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HISTORY OF TREATMENT

For Patients Receiving SUNLENCA® through Mississippi ADAP

ADAP requires that, to dispense Sunlenca, the patient must currently be receiving optimized background therapy (OBT) for at least eight weeks resulting in a viral load of at least 400 copies/mL (must be obtained within three (3) months prior to initiation date of Sunlenca), and the patient's infection must have shown resistance to **two (2) or more** antiretroviral medications from **three (3) or more of the four main classes** of antiretroviral medications (NRTI, NNRTI, PI, INSTI). *Please note that resistance to emtricitabine (FTC) or lamivudine (3TC) associated with the presence of the M184V/I RT mutation cannot be used for the purpose of determining eligibility for this criterion.*

INSTRUCTIONS: Utilizing this link, list below the current optimized background therapy (documentation may be requested).

Medication Name *(Brand or Generic)*	**Drug Class(es)**
1.	
2.	
3.	
4.	
5.	
6.	

INSTRUCTIONS: List below the agents to which infection has demonstrated resistance according to drug class (additional documentation may be requested).

Drug Class	**Medication Name *(Brand or Generic)***
Nucleoside Reverse Transcriptase Inhibitor (NRTI)	1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Non-nucleoside Reverse Transcriptase Inhibitor (NNRTI)	1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____
Protease Inhibitor (PI)	1. _____ 2. _____ 3. _____
Integrase Strand Transfer Inhibitor (INSTI)	1. _____ 2. _____ 3. _____
Other(s) *(list drug class)*	1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

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INSTRUCTIONS: List below the patient's current viral load (documentation to pharmacy or CAREWare is required).

***Note**: Laboratory values must be obtained within three (3) months prior to initiation date of Sunlenca.*

_____	_____
Viral Load (copies/mL)	Date Collected

I, <u>THE PROVIDER</u>, certify that all information provided on this form is true and accurate in accordance with the standards of the Mississippi AIDS Drug Assistance Program. Any information on this form that is incomplete is subject to further review, additional documentation, and extended time to review.

_____	_____
PROVIDER SIGNATURE	**DATE**

NO STAMPS OR REPRESENTATIVE SIGNATURE ACCEPTED