

## PHARMACY COVERAGE GUIDELINE

### SUNLENCA® (lenacapavir) oral and subcutaneous injection YEZTUGO® (lenacapavir) oral and subcutaneous injection Generic Equivalent (if available)

#### **This Pharmacy Coverage Guideline (PCG):**

- Provides information about the reasons, basis, and information sources we use for coverage decisions
- Is not an opinion that a drug (collectively “Service”) is clinically appropriate or inappropriate for a patient
- Is not a substitute for a provider’s judgment (Provider and patient are responsible for all decisions about appropriateness of care)
- Is subject to all provisions e.g. (benefit coverage, limits, and exclusions) in the member’s benefit plan; and
- Is subject to change as new information becomes available.

#### **Scope**

- This PCG applies to Commercial and/or Marketplace plans
- This PCG does not apply to the Federal Employee Program, Medicare Advantage, Medicaid or members of out-of-state Blue Cross and/or Blue Shield Plans

#### **Instructions & Guidance**

- To determine whether a member is eligible for the Service, read the entire PCG.
- This PCG is used for FDA approved indications including, but not limited to, a diagnosis and/or treatment with dosing, frequency, and duration.
- Use of a drug outside the FDA approved guidelines, refer to the appropriate Off-Label Use policy.
- The “Criteria” section outlines the factors and information we use to decide if the Service is medically necessary as defined in the Member’s benefit plan.
- The “Description” section describes the Service.
- The “Definition” section defines certain words, terms or items within the policy and may include tables and charts.
- The “Resources” section lists the information and materials we considered in developing this PCG
- **We do not accept patient use of samples as evidence of an initial course of treatment, justification for continuation of therapy, or evidence of adequate trial and failure.**
- Information about medications that require prior authorization is available at [www.azblue.com/pharmacy](http://www.azblue.com/pharmacy). You must fully complete the [request form](#) and provide chart notes, lab workup and any other supporting documentation. The prescribing provider must sign the form. Fax the form to BCBSAZ Pharmacy Management at (602) 864-3126 or email it to [Pharmacyprecert@azblue.com](mailto:Pharmacyprecert@azblue.com).

## Medical Necessity Requirements for SUNLENCA (lenacapavir)

### Criteria for Initial Therapy:

#### **Prescriber Qualifications**

- Prescribed by an Infectious Disease specialist or is in consultation with an Infectious Disease specialist

#### **Indication**

- Heavily treatment-experienced multidrug-resistant HIV-1 infection failing current antiretroviral regimen due to resistance, intolerance, or safety considerations

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#### Age Requirement

- 18 years of age

#### Baseline Clinical Evaluation

- Viral load greater than 400 copies/mL
- Resistance to at least **TWO** antiretroviral medications from each of at least three of the four classes (NRTI, NNRTI, PI, INSTI)
- Less than **TWO** active antiretroviral medications remaining at baseline due to resistance, intolerance, contraindication, or safety concerns

#### Brand Specific Criteria

- Have failure, contraindication or intolerance with **THREE** generic equivalents (if available) for at least three months each. **Note:** Any failure, contraindication, or intolerance to the generic drugs should be reported to the United States Food and Drug Administration (FDA) (see Definitions section)

#### Safety

- There is **NO** concomitant use with:
  - Strong CYP3A inducers (e.g., rifampin, rifabutin, rifapentine, carbamazepine, oxcarbazepine, phenobarbital, phenytoin, St. John's wort)
  - Moderate CYP3A inducers (e.g., bexarotene, bosentan, dabrafenib, dexamethasone, nafcillin, others)
  - P-gp, UGT1A1, and strong CYP3A inhibitors (e.g., erythromycin, ketoconazole, itraconazole, posaconazole, voriconazole, clarithromycin, others)
  - Atazanavir/cobicistat, atazanavir/ritonavir, efavirenz, nevirapine, tipranavir/ritonavir
  - Dihydroergotamine, ergotamine, methylergonovine
  - Tadalafil for pulmonary arterial hypertension
- There is **NONE** of the following:
  - Severe hepatic impairment (Child-Pugh Class C)
  - ESRD (estimated creatinine clearance less than 15 mL per minute)

#### Additional Requirements

- Must be used in combination with other antiretroviral(s) employing an optimized background regimen (OBR)

#### Documentation Requirements

- A completed request form must be submitted including:
  - Chart notes
  - Lab results (viral load, resistance testing)
  - Supporting clinical documentation

#### Initial Therapy Criteria Approval Duration

- 12 months OR end of plan year

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#### Criteria for Continuation of Therapy (renewal therapy):

**Note: Manufacturer assistance (e.g., coupons, samples, etc.) are not considered for continuation of therapy.**

#### Prescriber Qualifications

- Continues to be seen by an Infectious Disease specialist or is in consultation with an Infectious Disease specialist

#### Clinical Response

- **TWO** of the following:
  - Achieved and maintains a 70% reduction in viral load
  - Improved CD4+ cell count over baseline
  - No evidence of disease progression

#### Adherence

- Adherence to the prescribed therapy regimen has been documented

#### Brand Specific Criteria

- Have failure, contraindication or intolerance with **THREE** generic equivalents (if available) for at least three months each. **Note:** Any failure, contraindication, or intolerance to the generic drugs should be reported to the United States Food and Drug Administration (FDA) (see Definitions section)

#### Safety

- There is **NO** concomitant use with:
  - Strong CYP3A inducers (e.g., rifampin, rifabutin, rifapentine, carbamazepine, oxcarbazepine, phenobarbital, phenytoin, St. John's wort)
  - Moderate CYP3A inducers (e.g., bexarotene, bosentan, dabrafenib, dexamethasone, nafcillin, others)
  - P-gp, UGT1A1, and strong CYP3A inhibitors (e.g., erythromycin, ketoconazole, itraconazole, posaconazole, voriconazole, clarithromycin, others)
  - Atazanavir/cobicistat, atazanavir/ritonavir, efavirenz, nevirapine, tipranavir/ritonavir
  - Dihydroergotamine, ergotamine, methylergonovine
  - Tadalafil for pulmonary arterial hypertension
- There is **NONE** of the following:
  - Severe hepatic impairment (Child-Pugh Class C)
  - ESRD (estimated creatinine clearance less than 15 mL per minute)

#### Additional Requirements

- Must be used in combination with other antiretroviral(s) employing an optimized background regimen (OBR)

#### Documentation Requirements

- Chart notes
- Lab values confirming improvement
- Supporting clinical documentation

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### SUNLENCA® (lenacapavir) oral and subcutaneous injection YEZTUGO® (lenacapavir) oral and subcutaneous injection Generic Equivalent (if available)

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#### Continuation Therapy Criteria Approval Duration

- 12 months OR end of plan year

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### Medical Necessity Requirements for YEZTUGO (lenacapavir)

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#### Criteria for Initial Therapy:

##### Prescriber Qualifications

- Prescribed by an Infectious Disease specialist or is in consultation with an Infectious Disease specialist

##### Indication

- Pre-exposure prophylaxis (PrEP) to reduce risk of sexually acquired HIV-1 in those who are at risk for HIV-1 acquisition

##### Age Requirement

- 16 years of age or older weighing at least 35 kg

##### Baseline Clinical Evaluation

- Negative HIV-1 test prior to initiating and with each injection using FDA-approved test for acute or primary HIV-1 infection
- No FDA-label contraindication of unknown or positive HIV-1 status

##### Alternative Therapies

- Documented failure (trial for at least three months duration), contraindication, intolerance, or not a candidate for **BOTH**:
  - Emtricitabine/tenofovir disoproxil fumarate
  - Descovy

##### Brand Specific Criteria

- Have failure, contraindication or intolerance with **THREE** generic equivalents (if available) for at least three months each. **Note:** Any failure, contraindication, or intolerance to the generic drugs should be reported to the United States Food and Drug Administration (FDA) (see Definitions section)

##### Safety

- There is **NO** concomitant use with:
  - P-gp, UGT1A1, and strong CYP3A inhibitors (e.g., erythromycin, ketoconazole, itraconazole, posaconazole, voriconazole, clarithromycin, others)
- There is **NONE** of the following:
  - Severe hepatic impairment (Child-Pugh Class C)
  - ESRD (estimated creatinine clearance less than 15 mL per minute)

##### Documentation Requirements

- A completed request form must be submitted including:

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- Chart notes
- Lab results (HIV-1 negative test)
- Supporting clinical documentation

#### Initial Therapy Criteria Approval Duration

- 12 months OR end of plan year

#### Criteria for Continuation of Therapy (renewal therapy):

**Note: Manufacturer assistance (e.g., coupons, samples, etc.) are not considered for continuation of therapy.**

#### Prescriber Qualifications

- Continues to be seen by an Infectious Disease specialist or is in consultation with an Infectious Disease specialist

#### Clinical Response

- No evidence of HIV-1 infection

#### Adherence

- Adherence to the prescribed therapy regimen has been documented

#### Brand Specific Criteria

- Have failure, contraindication or intolerance with **THREE** generic equivalents (if available) for at least three months each. **Note:** Any failure, contraindication, or intolerance to the generic drugs should be reported to the United States Food and Drug Administration (FDA) (see Definitions section)

#### Safety

- There is **NO** concomitant use with:
  - P-gp, UGT1A1, and strong CYP3A inhibitors (e.g., erythromycin, ketoconazole, itraconazole, posaconazole, voriconazole, clarithromycin, others)
- There is **NONE** of the following:
  - Severe hepatic impairment (Child-Pugh Class C)
  - ESRD (estimated creatinine clearance less than 15 mL per minute)

#### Documentation Requirements

- Chart notes
- Lab values confirming safe use
- Supporting clinical documentation

#### Continuation Therapy Criteria Approval Duration

- 12 months OR end of plan year

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#### Criteria for Off-Label Use Requests:

Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

1. Off-Label Use of Non-Cancer Medications
2. Off-Label Use of Cancer Medications

#### Description:

Sunlenca (lenacapavir), a human immunodeficiency virus type 1 (HIV-1) capsid inhibitor, in combination with other antiretroviral(s), is indicated for the treatment of HIV-1 infection in heavily treatment-experienced adults with multidrug resistant HIV-1 infection failing their current antiretroviral regimen due to resistance, intolerance, or safety considerations. Yeztugo (lenacapavir), a human immunodeficiency virus type 1 (HIV-1) capsid inhibitor, is indicated for pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV-1 in adults and adolescents weighing at least 35 kg who are at risk for HIV-1 acquisition. Individuals must have a negative HIV-1 test prior to initiating Yeztugo (lenacapavir).

Lenacapavir inhibits HIV-1 replication by interfering with multiple essential steps of the viral lifecycle, including capsid-mediated nuclear uptake of HIV-1 proviral DNA (by blocking nuclear import proteins binding to capsid), virus assembly and release (by interfering with Gag/Gag-Pol functioning, reducing production of capsid protein subunits), and capsid core formation (by disrupting the rate of capsid subunit association, leading to malformed capsids).

Lenacapavir injection is only for subcutaneous administration into the abdomen by a healthcare provider.

#### Definitions:

U.S. Food and Drug Administration (FDA) MedWatch Forms for FDA Safety Reporting  
[MedWatch Forms for FDA Safety Reporting | FDA](#)

#### **Classification of antiretroviral drugs (agents listed alphabetically):**

Drug (abbreviations)	US Brand Name
<b>Nucleoside and nucleotide reverse transcriptase inhibitors (NRTIs)</b>	
Abacavir (ABC)	Ziagen
Emtricitabine (FTC)	Emtriva
Lamivudine (3TC)	Epivir
Stavudine (d4T)	Zerit

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Tenofovir alafenamide (TAF)	Vemlidy
Tenofovir disoproxil fumarate (TDF)	Viread
Zidovudine (ZDV, AZT)	Retrovir
<b>Non-nucleoside reverse transcriptase inhibitors (NNRTIs)</b>	
Delavirdine (DLV)	Rescriptor
Doravirine (DOR)	Pifeltro
Efavirenz (EFV)	Sustiva
Etravirine (ETR)	Intelence
Nevirapine (NVP)	Viramune, Viramune XR
Rilpivirine (RPV)	Edurant
<b>Protease inhibitors (PIs)</b>	
Atazanavir (ATV)	Reyataz
Atazanavir-cobicistat (ATV/COBI)	Evotaz
Darunavir (DRV)	Prezista
Darunavir-cobicistat (DRV/COBI)	Prezcobix
Fosamprenavir (FPV)	Lexiva
Indinavir (IDV)	Crixivan
Lopinavir/ritonavir boosting (LPV/r)	Kaletra
Nelfinavir (NFV)	Viracept
Ritonavir (RTV) (used as a pharmacokinetic boosting agent)	Norvir
Saquinavir (SQV)	Invirase
Tipranavir (TPV)	Aptivus
<b>Fusion inhibitor</b>	
Enfuvirtide (T-20)	Fuzeon
<b>Integrase strand transfer inhibitors (INSTIs)</b>	
Cabotegravir (CAB; oral formulation)	Vocabria
Dolutegravir (DTG)	Tivicay
Elvitegravir (EVG)	Vitekta

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Raltegravir (RAL)	Isentress, Isentress HD
<b>CCR5 antagonist</b>	
Maraviroc (MVC)	Selzentry
<b>Attachment inhibitor</b>	
Fostemsavir	Rukobia
<b>Post-attachment inhibitor</b>	
Ibalizumab-uijk	Trogarzo
<b>Fixed-dose combinations</b>	
Abacavir-lamivudine (ABC/3TC)	Epzicom
Abacavir-lamivudine-zidovudine (ABC/3TC/ZDV)	Trizivir
Bictegravir-emtricitabine-tenofovir alafenamide (BIC/FTC/TAF)	Biktarvy
Darunavir-cobicistat-emtricitabine-tenofovir alafenamide (DRV/COBI/FTC/TAF)	Symtuza
Dolutegravir-abacavir-lamivudine (DTG/ABC/3TC)	Triumeq
Dolutegravir-lamivudine (DTG/3TC)	Dovato
Dolutegravir-rilpivirine (DTG/RPV)	Juluca
Doravirine-lamivudine-tenofovir disoproxil fumarate (DOR/3TC/TDF)	Delstrigo
Efavirenz-emtricitabine-tenofovir disoproxil fumarate (EFV/FTC/TDF)	Atripla
Efavirenz- lamivudine -tenofovir disoproxil fumarate (EFV/FTC/TDF)	Symfi, Symfi Lo
Elvitegravir-cobicistat-emtricitabine-tenofovir alafenamide (ECF/TAF or EVG/COBI/FTC/TAF)	Genvoya
Elvitegravir-cobicistat-emtricitabine-tenofovir disoproxil fumarate (ECF/TDF or EVG/COBI/FTC/TDF)	Stribild
Rilpivirine-emtricitabine-tenofovir alafenamide (RPV/FTC/TAF)	Odefsey
Rilpivirine-emtricitabine-tenofovir disoproxil fumarate (RPV/FTC/TDF)	Complera
Tenofovir alafenamide-emtricitabine (TAF/FTC)	Descovy
Tenofovir disoproxil fumarate-emtricitabine (TDF/FTC)	Truvada
Zidovudine-lamivudine (ZDV/3TC)	Combivir
<b>Injectable combination</b>	

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Cabotegravir plus rilpivirine (CAB/RPV; extended-release injectable formulation)	Cabenuva
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**Resources:**

Sunlenca (lenacapavir) tab & subcutaneous injection product information, revised by Gilead Sciences. 11-2024. Available at DailyMed <http://dailymed.nlm.nih.gov>. Accessed November 07, 2025.

Yeztugo (lenacapavir) tab & subcutaneous injection product information, revised by Gilead Sciences. 06-2025. Available at DailyMed <http://dailymed.nlm.nih.gov>. Accessed November 07, 2025.

Darr ES. Evaluation of the treatment-experienced patient failing HIV therapy. In: UpToDate, Sax PE, Mitty J (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at <http://uptodate.com>. Literature current through December 2025. Topic last updated July 29, 2024. Accessed January 28, 2026.

Darr ES. Selecting an antiretroviral regimen for treatment-experienced patients with HIV who are failing therapy. In: UpToDate, Sax PE, Mitty J (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at <http://uptodate.com>. Literature current through December 2025. Topic last updated September 23, 2024. Accessed January 28, 2026.