HealthPAC
Health Program of Alameda County

TELEPHONE: 510-383-1790 FAX: 510-567-6850

Fuzeon (Enfuvirtide) Access Form

APPLICATION INFORMATION

Please fax completed application to the HealthPAC HIV Program at 510-567-6850.
For information on completing this form, please call: 510-383-1790.
Approval Period: Authorization to receive Fuzeon is given in six-month increments. A renewal application is required for continuation of Fuzeon every 6 months after approval by the program.

Section 1 Patient Name:

Birthdate: Program ID or SS#:

Section 2 ☐ **This patient has never taken Fuzeon.**

YES	NO	
☐	☐	1. Nadir CD4 of < 350 (**Submit a copy of the CD4 lab results**)
☐	☐	2. Two most recent viral loads (two) - detectable for **2** sequential readings within a six month period of application (**Submit two viral load measurements**)
☐	☐	3. This patient is treatment experienced.
☐	☐	4a. There is at least 1 other active antiretroviral drug that will be combined with Fuzeon.
		and/or
☐	☐	4b. This patient is enrolled in an antiretroviral clinical trial.

Section 3 ☐ **This patient was taking Fuzeon thru a previous payer source (i.e. Medi-Cal, private insurance, Medicare Part D)**

YES	NO	
☐	☐	1. Nadir CD4 of < 350 (**Submit a copy of the CD4 lab results**)
☐	☐	2. Two viral loads (two) -detectable for 2 sequential readings within a six month period **prior to starting Fuzeon** (**Submit two viral load measurements)**
☐	☐	3. This patient was treatment experienced at the time Fuzeon was started
☐	☐	4a. There was at least 1 other active antiretroviral drug that was combined with Fuzeon.
		and/or
☐	☐	4b. This patient was enrolled in an antiretroviral clinical trial at the time Fuzeon was started.

Section 4 ☐ **This patient is continuing on Fuzeon (previously received program coverage for Fuzeon)**

YES	NO	
☐	☐	There is documented clinical improvement/stabilized condition while on Fuzeon

DATE:	To the best of my knowledge, I certify that the above is accurate and true.	
Prescriber Name	Prescriber's Signature	
Phone #	Fax #	DEA #
Pharmacy Name	NABP/NPI #	
Phone #	Fax #	

Ramsell