Alabama Drug Assistance Program (ADAP)

Supplemental/Authorization Form for Fuzeon® (enfuvirtide)

TELEPHONE: 888-311-7632 FAX: 800-848-4241

Please complete the form below for determination of treatment authorization

Application Information:

Approval Period: Authorization to receive Fuzeon™ is given in 6-month increments. A new application must be submitted each 6 months (birth month and half birth month).

Approval notification: Clinicians will be notified of the approval decision by Ramsell.

Prescriber Name and Signature must be included. Please fax completed application to Ramsell at 800-848-4241. For additional information, call the Ramsell Help Desk at: 1-888-311-7632.

All supporting labs and chart documentation are REQUIRED for approval of this request.

Patient First and Last Name: Patient DOB: RW ID #:

What is the planned treatment regimen and duration? (Please fill in):

- ☐ Drug Name including strength and daily dosing :

_____

Check the box that applies

- ☐ This patient is not taking Fuzeon™. (New Start Patient)
- ☐ This patient has been taking Fuzeon™ for six months or less.
- ☐ This patient has been taking Fuzeon™ for more than six months that was previously approved through the Alabama ADAP Program

Please confirm the following statements: (check all that apply)

- ☐ This patient is not receiving or waiting to receive Fuzeon™ from Roche Pharmaceutical company
- ☐ This patient is ARV treatment experienced
- ☐ There is evidence of viral replication despite ongoing ARV therapy with a VL >1000 copies/ml and a second confirmatory test (within the last 3 months)
- ☐ CD4 <200cells (within the last 3 months)
- ☐ This patient has been under my care for ≥ 4months and he/she consistently keeps appointments and is believed to have excellent adherence to ARV therapy or a plan has been made to facilitate excellent adherence to the Fuzeon-containing regimen

For all clinicians

- ☐ I certify that Fuzeon™ therapy is/continues to be successful and alternatives to continuing Fuzeon™ have been considered and ruled out
- ☐ My practice or clinic has the capacity and expertise to educate the patient or caregiver regarding the preparation and administration of Fuzeon™. For assistance call Terri Jenkins, MSN-ED, RN ADAP Manager at 334-206-9441
- ☐ The patient or caregiver can reconstitute and administer the subcutaneous injections twice a day and properly dispose of needles and syringes. For assistance call Terri Jenkins, MSN-ED, RN ADAP Manager at 334-206-9441
- ☐ I have reviewed the clinical information on the proposed prescription for possible drug-drug interactions with other medications currently prescribed to the patient

Date: **To the best of my knowledge, I certify that the above is accurate and true.**

Prescriber Name Prescriber Signature

Phone # Fax #

Pharmacy Name Pharmacy Phone # Fax #

REQUIRED DOCUMENTATION - Please submit ALL required clinical notes/ lab reports in reference to this request. Failure to provide documentation will delay decision process.

☐ Most recent CD4 (within the last 3 months) ☐ Most recent HIV viral load (within the last 3 months) ☐ Most recent genotype (done while on most recent therapy)