Print Form

ILLINOIS Department of Public Health

Ryan White Part B Program

Medication Assistance Program (MAP)

Pre-Approval for FUZEON (enfuvirtide)

TELEPHONE: 888-311-7685 FAX: 800-848-4241 Ramsell

Prescriptions for FUZEON are only available with pre-approval through the Medication Assistance Program. You can click on the name of the medication to be taken directly to the specific prescribing guidelines. **NOTE:** There is a limit of 15 clients that can be approved for assistance with Fuzeon at any given time. Physicians will be notified is applicant is approved.

To be eligible for this pre-approval, a client must meet all of the following:

- Be currently enrolled in MAP and eligible for MAP assistance
- Have been denied medication coverage by their insurance plan (if applicable). Documentation of denial must be provided.
- Have experienced failure of the current HAART regimen
- Have a current CD4 count less than 500 – results must be dated within the past 6 months and documentation must be provided.
- Have a current viral load greater than 1,000 copies per mL – results must be dated within the past 6 months and documentation must be provided.
- Have resistance testing performed within the past 3 months which shows that a medically appropriate 3 drug regimen cannot be constructed utilizing drugs other than Fuzeon.

First Name	Middle Initial	Last Name
Member ID	**Date of Birth**	**RW ID (if known)**

Drug name, form and strength	Quantity requested:	Day supply:

Most Current CD4 Count	Most Recent Viral Load
Has resistance testing been performed	**Who will administer medication to client?**
☐ YES ☐ NO	
Who will assume responsibility for medication upon shipment arrival?	
Address where medication will be sent if approved?	

Provider must acknowledge the following with initials:

_____ I have reviewed the prescribing guidelines for possible interactions and issues of the medication regimen.

_____ Patient has been counseled on the high cost of treatment and is willing to be 100% adherent to treatment regimen.

Date:	**To the best of my knowledge, I certify that the above is accurate and true.**	
Provider Name (Print)	Provider Signature	
Clinic Name:	Phone #	Fax #
Pharmacy Name	Pharmacy Phone #	Fax #

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

☐ Denied medication coverage by insurance plan (if applicable) ☐ Recent CD4 <500 (within the last 6 months)
☐ Recent HIV viral load >1,000 copies/mL (within the last 6 months) ☐ Resistance Test (within the last 3 months)

Submit: Please fax completed application to Ramsell at **800-848-4241**.
For additional information, call the Ramsell Help Desk at: 1-888-311-7685.