Fuzeon™ Prior Authorization Application

Washington State Early Intervention Program (EIP)

PATIENT INFORMATION (Clinician may complete for patient if patient verbally agrees.)

Name of Patient: _____ **DOB:** _____

Social Security # or Early Intervention Program #: _____

- ☐ Patient is willing to take two injections daily.
- ☐ Patient is aware of the very common Fuzeon injection site reactions.

APPLICATION INFORMATION

Financial Eligibility: Patients must have current non-temporary eligibility in the Washington State Early Intervention Program (EIP). They must maintain program coverage throughout their Fuzeon treatment. If Ramsell cannot confirm eligibility, they will deny this application.
Approval Period: Authorization to receive Fuzeon is given in six-month increments. A new application must be submitted each six months.
Limits: Enrollment for Fuzeon is limited. Approval of this application is dependent on availability.
Approval notification: Clinicians will be notified of the approval decision.

MEDICAL ELIGIBILITY (To be completed by the patient's clinician)

Check the box that applies to this patient and follow the instructions that follow for that box and complete the clinician information at the end of the form.

☐ **A. This patient has been taking Fuzeon for six months or less.**

1. Fax this application along with proof (e.g. patient RX profile history) that the patient has been taking Fuzeon OR the name of the pharmacy where the patient has been receiving Fuzeon for confirmation purposes.

☐ **B. This patient has been taking Fuzeon for more than six months that was previously approved thru the Early Intervention Program (EIP)**

☐ 1. Fuzeon therapy continues to be successful and alternatives to continuing enfuvirtide have been considered and ruled out.

☐ **C. This patient has been taking Fuzeon for more than six months thru a payer source other than EIP. To receive approval for another six months of Fuzeon, you must verify that this patient's viral load has decreased by at least 0.5 log or the CD4 count has increased by 50 since starting Fuzeon.**

1. Fax this application along with pre-Fuzeon and on-Fuzeon viral load measurements and CD4 results.

☐ **D. This patient is not taking Fuzeon.**

- Fax this signed form and the following documents:
  1. Most recent CD4 count (one must have been done within the last 2 months)
  2. Most recent viral load measurements done while on most recent therapy (two)
  3. Most recent genotype (done while on most recent therapy)
  4. Complete this checklist of criteria for Fuzeon coverage. All must apply before submitting this application.

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☐ Current CD4 <=250 or AIDS-defining illness

☐ Antiretroviral Treatment experienced

☐ Significant viral replication while on the most recent antiretroviral therapy with viral load greater than 3,000 on the last two tests done after at least 3 months of that therapy

☐ Antiretroviral treatment history and all HIV genotypes (including one done on the most recent ARV therapy) have been reviewed to determine that:

1. An effective 3-drug regimen cannot be constructed without Fuzeon AND
2. Patient failed at least two prior regimens on the basis of resistance AND
3. Patient is believed to tolerate and be sensitive to at least one other ARV to combine with Fuzeon OR current CD4 is less than 100.

☐ No more than five antiretrovirals will be prescribed including Fuzeon (including Ritonavir if used for pharmacokinetic boosting).

☐ Prescriber's clinic has the capacity and expertise to educate the patient regarding Fuzeon shipping, receiving, preparation and administration *or* arrangements will be made for this education with an expert pharmacy.

☐ Patient consistently keeps appointments and is believed to have excellent adherence to antiretroviral therapy or a plan has been made to facilitate excellent adherence to the Fuzeon-containing regimen.

☐ Patient has or will be offered immunization against pneumococcus

☐ I care for more than 5 people with HIV **or** I have consulted with an HIV expert regarding the use of Fuzeon in this case. (Free expert consultation information is attached)

☐ I will prescribe the client standard syringes if they have problems with the retractable syringes supplied with Fuzeon.

CLINICIAN INFORMATION

Printed name of clinician completing the form _____

Clinician signature _____ Date _____

Phone number _____ Fax number _____

Fax all required materials to Ramsell 1.800.848.4241. Ramsell is the pharmacy benefit manager for the Washington State Early Intervention Program (EIP). Ramsell will notify all clinicians following review of this application.

Upon notification of approval, clinicians must contact the client's pharmacy of choice with a prescription for the client.
Kaiser clinicians must contact a Kaiser pharmacy for dispensing of Fuzeon to plan members.
For information on:

- Completion or approval of this form: 1-888-311-7632 ext. 2653 or 2635
- EIP eligibility call: 1-877-376-9316