

REQUEST FOR COVERAGE OF FUZEON™ (ENFUVIRTIDE)

Patient Data

Patient Name: _____	GHI ID#: _____	DOB: _____
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Pertinent Laboratory History

CURRENT:	Viral Load: _____ CD4 cell count: _____	Date: _____
PAST:	Viral Load: _____ CD4 cell count: _____	Date: _____
	Viral Load: _____ CD4 cell count: _____	Date: _____
	Viral Load: _____ CD4 cell count: _____	Date: _____
BASELINE: (if available)	Viral Load: _____ CD4 cell count: _____	Date: _____

Current/Complete HAART Drug Regimen:

Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTI's)		
<input type="checkbox"/> Rescriptor® (delavirdine)	<input type="checkbox"/> Viramune® (nevirapine)	<input type="checkbox"/> Intelence® (etravirine)
<input type="checkbox"/> Sustiva® (efavirenz)		
Nucleoside Reverse Transcriptase Inhibitors (NRTI's)		
<input type="checkbox"/> Ziagen® (abacavir)	<input type="checkbox"/> Videx® (didanosine)	<input type="checkbox"/> Combivir® (lamivudine/zidovudine)
<input type="checkbox"/> Epzicom® (abacavir/lamivudine)	<input type="checkbox"/> Emtriva® (emtricitabine)	
<input type="checkbox"/> Zerit® (Stavudine)	<input type="checkbox"/> Epivir® (lamivudine)	
<input type="checkbox"/> Viread® (tenofovir)	<input type="checkbox"/> Retrovir® (zidovudine)	
Protease Inhibitors (PI)		
<input type="checkbox"/> Agenerase® (amprenavir)	<input type="checkbox"/> Prezista® (darunavir)	<input type="checkbox"/> Kaletra® (lopinavir/ritonavir)
<input type="checkbox"/> Reyataz® (atazanavir)	<input type="checkbox"/> Lexiva® (fosamprenavir)	<input type="checkbox"/> Aptivus® (tipranavir)
<input type="checkbox"/> Crixivan® (indinavir)	<input type="checkbox"/> Invirase® (saquinavir)	<input type="checkbox"/> Norvir® (ritonavir)
Entry Inhibitors	Integrase Inhibitors	Miscellaneous Mixed Combination
<input type="checkbox"/> Selzentry® (maraviroc)	<input type="checkbox"/> Isentress® (raltegravir)	<input type="checkbox"/> Atripla® (efavirenz/emtricitabine/tenofovir)

Please List Prior HIV-medication Failures:

Prescription Information:

DRUG
<input type="checkbox"/> Fuzeon 90mcg SC twice daily.
<input type="checkbox"/> Fuzeon 2mg/kg SC twice daily*
(Dose: _____)
* Please include weight for pediatric use.
(Weight: _____)

Physician Data

Physician Name: _____	Specialty: _____	License #: _____
Telephone#: _____	FAX#: _____	
Please complete form and fax to: Fax to: 1-877-300-9695		
Director, Clinical Pharmacy Programs GHI/GHI HMO Pharmacy Services 55 Water Street, 12 th Floor South New York, NY 10041 Phone: 1-877-444-3657		