Georgia ADAP Prior Approval Application

Fuzeon

DATE OF REQUEST:	

CLIENT INFORMATION:	
Client Name (Last, First, M):	
District/Clinic where the client is seen:	

Client/Caregiver:		
1) Patient is willing to take (or caregiver to administer) medications as directed.	☐ Yes	☐ No
2) Patient has prior evidence of adherence to therapy and medical care; and prescriber has reasonable expectation that adherent behavior will continue.	☐ Yes	☐ No
3) Patient's home has sufficient storage at the proper temperature.	☐ Yes	☐ No

DRUGS REQUESTED & REQUIRED INFORMATION:

Please complete the corresponding section for the specific drugs requested and check the appropriate boxes, or supply the response/supporting documentation.

☐ **Fuzeon (Enfuviritide)**

1) Current antiretroviral regimen:	

2) Please attach copies of the most recent viral load, CD4 count and all available resistance testing.

3) Proposed optimized regimen:	

4) Does the client have a history of moderate to severe adverse events/intolerances/ allergies to medications? ☐ Yes ☐ No

- **If yes**, what medications?	
- Describe the reaction:	

5) Please attach the most recent prescribers note and a list of all current non-HIV medications to asses if there are potential drug interactions that support requiring salvage therapy.

6) Does the client have a history of enrollment in a recent study or Expanded Access Program? ***(If yes**, please provide documentation.)* ☐ Yes ☐ No

If a client's regimen includes Fuzeon, the Georgia ADAP recommends *completing a "Fuzeon Nurse Connections" enrollment form to arrange for a home visit from a Fuzeon Nurse Educator to help the client to become confident in their ability to reconstitute and inject Fuzeon. The form is available at* ***www.fuzeon.com*** *or via phone at 877-4FUZEON (877-438-9366).*

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Prescriber Information:			
Provider Name (Last, First, M):		Phone:	
Email:		Signature:	

Clinical Request Determination:			
Date Received:		Date of Decision:	
☐ Request approved ☐ Request Denied			
Medical Advisor (Last, First, M):			
Phone:		Email:	
Medical Advisor/ Prescriber Signature:			

Comments/Additional Information or Instructions:

Provider/Prescriber Guidelines:
Patient must have a repeat HIV viral load within 2-8 weeks from medication initiation and if the HIV RNA is detectable at 2-8 weeks, repeat testing every 4-8 weeks until viral load is suppressed to <200 copies/mL.
If CD4 and/or viral load have not improved, clinical improvement (or clinically stable if condition was worsening before) must be documented for continuation of the new regimen.
The prescriber must review the state guidelines and/or restrictions concerning the use of these medications to determine that the patient qualifies.
The prescriber should be an experienced HIV/AIDS provider or should consult with a specialist and must have sufficient office/clinic capability to provide patient education and monitoring.
Guidelines: https://clinicalinfo.hiv.gov/en/guidelines