Kansas Medical Assistance Program
P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

Enfuvirtide (Fuzeon®)
Prior Authorization Request Form

Beneficiary Name: _____

Beneficiary Medicaid ID #: _____ Date Of Birth: _____/_____/_____

Pharmacy Name: _____

Pharmacy Medicaid ID#: _____ Pharmacy NPI#: _____

Phone Number: (_____)_____ __Fax Number: (_____)_____

Drug Name: _____ NDC Requested: _____

Prescribing Physician's Name: _____

Physician Medicaid ID#: _____ Physician NPI#: _____

Phone Number: (_____)_____ Fax Number: (_____)_____

1. Please indicate the diagnosis for which Enfuvirtide is being prescribed:
_____

2. Is patient pregnant or breastfeeding? Yes_____ No_____

3. Is this patient currently receiving Fuzeon® via an expanded access program? Yes_____ No_____

4. Has the patient been on antiretroviral agents in the past? Yes_____ No_____

5. Documentation of HIV/RNA despite ongoing ARV therapy and viral load (HIV/RNA) greater than 1000 copies/ml.
Yes_____ No_____

6. Has a recent HIV resistance test (genotype) been conducted and ARV history review for an optimal base regimen **OF AT LEAST TWO ACTIVE AND TOLERATED ARVs**? Yes_____ No_____

7. Will Fuzeon® be used as part of an alternative salvage regime for a patient with end-stage disease who is at risk of serious Opportunistic Infections or death? Yes_____ No_____

8. Has the patient been compliant to the treatment recommended by the physician? Yes_____ No_____

9. Can the patient or his/her primary care giver reconstitute and administer the subcutaneous injections bid and properly dispose of the used syringes and needles? Yes_____ No_____

10. Is the patient up to date on pneumococcal and influenza immunizations? If not, please ensure that the patient is appropriately immunized. Yes_____ No_____

Prescribing Physician's Signature: _____ Date: ___/___/_____

Completed form should be faxed to the Prior Authorization Unit at 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.