State of Illinois
Illinois Department of Public Health

Ryan White Part B ADAP Medication Assistance Program (MAP)

Application for Pre Approval of Fuzeon® (enfuvirtide) Assistance

(click on the name to take you directly to the specific Prescribing Guidelines)

To be eligible for Assistance for Fuzeon, a client must meet all of the following:

1. Be currently enrolled in ADAP/MAP and eligible to receive services.
2. Have been denied medication coverage by their insurance plan (if applicable) - **(documentation required)**
3. Have experienced failure of the current HAART regimen.
4. Have a CD4 count less than 500 - **(documentation required)**
5. Have viral load greater than 1,000 - **(documentation required)**
6. Resistance testing (performed within the past 3 months) and based on the test results, medically appropriate 3 drug regimen cannot be constructed utilizing drugs other than Fuzeon.

Complete the following:

Applicant's Name_____
Legal First Middle Last

Social Security Number _____ **Date of Birth** _____

Address _____

City _____ **State**_____ **ZIP Code** _____

Most recent CD4 count: _____ - results must be dated within the past 6 months - **(documentation required)**

Most recent Viral Load: _____ - results must be dated within the past 6 months - **(documentation required)**

Has Resistance Testing Been performed? ☐ **Y** / ☐ **N** **(documentation required for "Yes" answer)**

- **Results within past 3 months and indicate medically appropriate 3 drug regimen cannot utilize drugs other than Fuzeon**

Who will administer Fuzeon to client?_____

Who will assume responsibility for Fuzeon upon shipment arrival? _____

Address where drug will be sent if approved:_____

*****NOTE: A limit of 15 clients can be approved for Fuzeon assistance at a given time.***
Physicians will be notified if applicant is approved and instructed where to send or fax the prescription.

Physician Name: (Print) _____ **Clinic:** _____

Phone Number: _____ **Fax Number:** _____

Provider Signature: _____

Provider must acknowledge the following with initials:

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

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

Submit to: Illinois Department of Public Health **or** Fax to: 217-785-8013
525 W. Jefferson St., 1st Floor, Springfield, IL 62761

IDPH USE ONLY: Authorization Approved? ❑ YES ❑ NO Authorization Number: _____

Authorization Effective Date: _____ Authorization Expiration Date: _____