Return Completed Form to:
MADAP
500 N. Calvert Street, 5th Floor
Baltimore, MD 21202
Confidential Fax: (410) 333-2608
Phone: (410) 767-6535

MADAP Office Use Only
Date Received: _____ MADAP Exp.: _____
Authorized: ___Yes ___No Initials: _____
Updated in System: ____Yes ___No

Patient request for enfuvirtide (Fuzeon®)

Client Name_____ **MADAP ID Number:** 94_____

Instructions: In order for a MADAP client to receive *enfuvirtide* coverage, the prescribing clinician must complete and submit this form for consideration of eligibility. The request will be reviewed by a panel of physicians appointed by the Director of the AIDS Administration.

Patients must have a recent CD4 count of less than 200, a viral load greater than 10,000 copies/mL, and resistance testing showing at least two active antiretrovirals. All lab results must be within prior three months of request.

1. **Patient education & enfuvirtide monitoring**

Please provide a summary of the patient education to be provided to the patient, and indicate who will provide the education (use additional page if necessary):

_____

_____

Please provide a summary of how treatment with *enfuvirtide* will be monitored (use additional page if necessary):

_____

_____

2. **Clinical & Laboratory Results**

A. Current CD4 _____ Date of lab test _____ (must be within prior 3 months)
B. Current viral load _____ Date of lab test _____ (must be within prior 3 months)
C. Date of HIV resistance testing (genotypic or phenotypic) _____ Copy of lab report must be submitted
D. List patient's antiretroviral treatment regimen at time of resistance testing:

_____

3. **Prior NNRTI Information (use additional page if necessary)**

NNRTI: _____ Start Date_____ End Date _____
Reason for discontinuation: _____

NNRTI: _____ Start Date_____ End Date _____
Reason for discontinuation: _____

4. **List planned treatment regimen- Requires a minimum of two active antiretrovirals, plus *enfuvirtide*.**

_____

_____

Clinician Name: _____ **Clinician Signature:** _____**Date** _____

Address: _____ **License Number & State:** _____

Phone: _____ **Fax:** _____