

**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	
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Authorized: <input type="checkbox"/> Yes <input type="checkbox"/> No	Initials: _____
Updated in System: <input type="checkbox"/> Yes <input type="checkbox"/> 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**

<p>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):</p> <p>_____</p> <p>_____</p> <p>Please provide a summary of how treatment with <i>enfuvirtide</i> will be monitored (use additional page if necessary):</p> <p>_____</p> <p>_____</p>
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**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: \_\_\_\_\_