

Complete Patient and Physician information (PLEASE PRINT)

| | | |
|-----------|--------------|-----------------|
| STEP 1 | Member Name: | Physician Name: |
| | Address: | Address: |
| | Member ID: | Phone #: |
| | Member DOB: | Fax #: |

If Applicable: Pharmacy Name: _____
 Pharmacy Phone: _____

STEP 2 Complete the Clinical Assessment:

| | | | | |
|--|--|---|--|--|
| Diagnosis | <input type="checkbox"/> Treatment resistant HIV-1 infection | | <input type="checkbox"/> Other (please state): _____ | |
| | <input type="checkbox"/> Viral replication (at least 5,000 copies of HIV-1 RNA per mL of plasma) has continued despite therapy with all three classes of anti-retroviral drugs. | | | |
| Clinical Consideration | Previous Drug Therapy (must include one drug from each class) | NNRTI <input type="checkbox"/> Rescriptor <input type="checkbox"/> Sustiva <input type="checkbox"/> Viramune | NRTI <input type="checkbox"/> Epivir <input type="checkbox"/> Hivid <input type="checkbox"/> Retrovir <input type="checkbox"/> Trizivir <input type="checkbox"/> Combivir <input type="checkbox"/> Viread <input type="checkbox"/> Videx <input type="checkbox"/> Zerit <input type="checkbox"/> Ziagen | PI <input type="checkbox"/> Agenerase <input type="checkbox"/> Kaletra <input type="checkbox"/> Crixivan <input type="checkbox"/> Norvir <input type="checkbox"/> Saquinavir <input type="checkbox"/> Viracept <input type="checkbox"/> Inverase |
| | | Diagnosis: ICD-9 Code #/ Description (required): _____ | | |
| Supporting Documentation | Please attach a copy of the prescription or provide ALL of the information below: Fuzeon [®] (enfuvirtide) | | | |
| | Strength _____ Sig _____ Qty _____ Refills _____ | | | |
| Please attach all relevant medical records and test results. Incomplete forms will not be processed. | | | | |

STEP 3 I certify that the above is correct and accurate to the best of my knowledge (please sign and date).

 Prescriber Signature

 Date

**STEP 4 Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:
 970-248-5034**

Pharmacy Technician initials _____ Date Initiated _____

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