

Complete Patient and Physician information (PLEASE PRINT)

STEP
1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:
	Tax ID or NPI Number:

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):	
Clinical Consideration	<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.			
	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"/> Efavirenz <input type="checkbox"/> Zidovudine <input type="checkbox"/> Zalcitabine <input type="checkbox"/> Didanosine <input type="checkbox"/> Zalcitabine <input type="checkbox"/> Zalcitabine <input type="checkbox"/> Zalcitabine	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"/> Inverse
Supporting Documentation	Diagnosis: ICD-9 Code #/ Description / J Code (required):			
	Please attach a copy of the prescription or provide ALL of the information below: Fuzeon [®] (enfuviritide)			
	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**

Name of Person filling out form: _____

Pharmacy Technician initials _____ Date Initiated _____

Confidentiality Notice:

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