

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"/> Epivir <input type="checkbox"/> Retrovir <input type="checkbox"/> Combivir <input type="checkbox"/> Videx <input type="checkbox"/> Ziagen
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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