Health PEI

SPECIAL AUTHORIZATION REQUEST

ENFUVIRTIDE (FUZEON)

Fax requests to (902) 368-4905 **OR** mail requests to PEI Pharmacare, P.O. Box 2000, Charlottetown, PE, C1A 7N8

SECTION 1 – PATIENT INFORMATION

PERSONAL HEALTH NUMBER (PHN)		PATIENT (FAMILY) NAME	PATIENT (GIVEN) NAME(S)
DATE OF BIRTH (YYYY/MM/DD)	PATIENT WEIGHT (kg)	PATIENT'S MAILING ADDRESS	

SECTION 2 – PRESCRIBER INFORMATION

NAME AND MAILING ADDRESS	APPLICATION DATE YYYY MM DD
	PRESCRIBER'S TELEPHONE # AREA CODE
	PRESCRIBER'S FAX # AREA CODE

SECTION 3 – MEDICATION DETAIL INFORMATION

REQUESTED DRUG (PLEASE CHECK ONE) ☐ **Enfuvirtide (Fuzeon)**	DOSAGE AND FREQUENCY

Requests for coverage will be considered on a case-by-case basis for patients who meet the following criteria.

CHECK/FILL OUT RELEVANT BOXES BELOW

- ☐ A CD4 count greater than 100 cells/mm^3; AND
- ☐ A viral load less tha 100,000 copies/mL; AND
- ☐ Has previously received less than 11 antiretroviral agents; AND
- ☐ Therapy with enfurvirtide planned in combination with at laest one other retroviral drug to which sensitivity has been demonstrated on resistance testing.

OTHER COMMENTS, INCLUDING COPIES OF RELEVANT TEST RESULTS:

PEI Pharmacare may request additional documentation to support this Special Authorization Request. Personal information on this form is collected under section 31(c) of Prince Edward Island's Freedom of Information & Protection of Privacy (FOIPP) Act as it relates directly to and is necessary for providing services under the PEI High-Cost Drugs Program.

If you have any questions about this collection of personal information, you may contact the program office at 902-368-4947 or at the address at the top of the form.

PRESCRIBER SIGNATURE (REQUIRED) **DATE**

11HPE15-30356

FORMS WITH INFORMATION MISSING WILL BE RETURNED FOR COMPLETION.
APPROVALS WILL NOT BE CONSIDERED AT DOSES OR DOSING INTERVALS OUTSIDE OF PEI GUIDELINES.