STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES

Office of Pharmacy Service
Prior Authorization Criteria

Fuzeon® (enfuruvide)

Prior Authorization Request Form

Prior authorization requests for Fuzeon will be approved if the following criteria are met:

1. Diagnosis of advanced HIV infection; **AND**
2. Patient is six (6) years of age or older; **AND**
3. Documented failure of trials of multiple combinations of oral anti-viral therapy. (This is demonstrated by the lack of appropriate response of the CD4 cell count.) Fuzeon will not be approved for monotherapy or for the initial treatment of patients with an HIV diagnosis; **AND**
4. Prior approval will be given for a maximum of twenty-four (24) weeks. Further documentation of the success of the enfuviritide treatment will be necessary to continue therapy; **AND**
5. Doses of more than ninety (90) mg (ml) twice daily will not be approved. In pediatric patients, doses of more than 2mg/kg will not be approved.

Review and approved
WV DUR Board 2010