FUZEON® MEDICATION HISTORY FORM
DOCUMENTING FAILURE TO ORAL ANTI-RETROVIRAL THERAPY
Fax to Pharmacy Services at **855-811-9332** or to speak to a Representative, call **888-602-3741**. *Form must be completed for processing.*

Patient Name:___________________________ **Patient ID #**____________________**Patient Phone #**_______________________

Patient Address: ____

Physician Name: ____ **NPI #**____

Physician Address: ____

Phone #____________________________ **Fax #**________________________**Contact Person**____________________________

(Form must be completed with all requested information in order to help establish the medical necessity of Fuzeon before utilizing all formulary alternatives. Failure to provide documentation may result in delays and/or denial of Fuzeon.)

	Start Date	End Date	Viral Load before treatment & lab date	CD_4 Count before treatment & lab date	Viral Load post treatment & lab date	CD_4 Count post treatment & lab date
1st Drug Regimen						
2nd Drug Regimen						
3rd Drug Regimen						
4th Drug Regimen						
5th Drug Regimen						
6th Drug Regimen						
7thDrug Regimen						

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