FUZEON® PRIOR AUTHORIZATION PROCEDURE and REQUIRED INFORMATION FORM
Fax to Pharmacy Services at **855-811-9332**, or to speak to a Representative, call **888-602-3741**. *Form must be completed for processing.*

AmeriHealth Caritas District of Columbia

Patient Name:_____ **Patient ID #** _____

Patient Address: _____ **Patient Phone #** _____

Physician Name:_____ **NPI #**_____

Physician Address: _____

Physician Phone #_____ **Fax #**_____ **Contact Person**_____

Fuzeon Rx:_____ **Physician Signature**:_____

PART A: Directions for Fuzeon® Prior Authorization Request:

- **For Prior Authorization,** fax all requested information in **PART B** or **PART C** (whichever is applicable) to AmeriHealth Caritas District of Columbia Pharmacy Services. Complete *Fuzeon® Medication History Form* for Prior Authorization of initial and *HIV-RNA Tracking Form* for continuation of Fuzeon®**.**

PART B: Required Medical Information for Initial Prior Authorization of Fuzeon®.

1. A detailed medication history complete the "*Fuzeon® Medication History Form*" documenting prior treatment failures, including corresponding HIV-1 RNA levels and CD_4 counts.

2. Has the patient tried and failed one oral drug regimen that was based on genotype and phenotype sensitivity testing? (circle) Yes / No If no, please provide a medical reason for not utilizing one sensitivity assisted oral drug regimen prior to ordering Fuzeon. Attach additional information if necessary.

   _____

   _____

3. Current HIV-1 RNA level and CD_4 count - include dates of lab work (either comment below or fax lab reports). *Use HIV-1 RNA Tracking Form and fax with request*.

   _____

4. Has the patient tried at least 2 different drug regimens containing 2 different NRTIs and PIs? (Circle) Yes / No If yes please indicate below. If no, please provide a documented medical reason for not utilizing 2 different regimens containing 2 different NRTIs and PIs - Attach additional information if necessary.

   _____

   _____

5. Please comment on the patient level of adherence to previous oral medications.

   _____

   _____

6. Please indicate background drug therapy intended to be given with Fuzeon:

   _____

7. Documentation of baseline (or when the member was on oral medication) genotypic and phenotypic sensitivity analysis. Fax lab reports with request**.**

PART C: For Reauthorization After 16 Weeks of Therapy (Each reauthorization will be for an additional 6 months – same criteria applies each time)

1. Reauthorization requires updated HIV-RNA and CD_4 levels, as well as specific documented clinical benefits (e.g. weight gain, etc) the patient is experiencing by using Fuzeon®. *Use HIV-1 RNA Tracking Form and fax with request*. **If the patient is beginning to fail therapy while on Fuzeon (increasing VL &/or decreasing CD4), an updated genotype/phenotype lab result will need to be submitted to show continued susceptibly to Fuzeon.**
2. Please indicate current background drug therapy: