



FUZEON® PROCEDURE and REQUIRED INFORMATION FORM

Fax non-urgent requests to PerformRx Pharmacy Services at **877-693-8280** or urgent requests to **877-693-8476**. Urgent requests should be reserved for situations in which the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. To speak to a representative, call **800-578-0898**. *Form must be completed for processing*

Patient Name: _____ Patient ID # _____ Patient Phone # _____
Patient Address: _____
Physician Name: _____ NPI # _____
Physician Address: _____
Physician Phone # _____ Fax # _____ Contact Person _____
Fuzeon Rx: _____ Physician Signature: _____

PART A: Directions for Fuzeon® Request:

- **For Coverage Determination**, fax all requested information in **PART B** or **PART C** (whichever is applicable) to PerformRx 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 Coverage Determination of Fuzeon®.

1. A detailed medication history complete the "*Fuzeon® Medication History Form*" documenting prior treatment failures, including corresponding HIV-1 RNA levels and CD4 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 CD4 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.

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

1. Reauthorization requires updated HIV-RNA and CD4 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.*
2. Please indicate current background drug therapy:
