

**FUZEON® MEDICATION HISTORY FORM**

**DOCUMENTING FAILURE TO ORAL ANTI-RETROVIRAL THERAPY**

Fax to Keystone Mercy Pharmacy Services at **215-937-5018** or to speak to a representative call **800-588-6767**. *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 <sub>4</sub> Count before treatment & lab date	Viral Load post treatment & lab date	CD <sub>4</sub> Count post treatment & lab date
1 <sup>st</sup> Drug Regimen						
2 <sup>nd</sup> Drug Regimen						
3 <sup>rd</sup> Drug Regimen						
4 <sup>th</sup> Drug Regimen						
5 <sup>th</sup> Drug Regimen						
6 <sup>th</sup> Drug Regimen						
7 <sup>th</sup> Drug Regimen						