

**FUZEON® PRIOR AUTHORIZATION PROCEDURE and REQUIRED INFORMATION FORM**

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: \_\_\_\_\_

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 Keystone Mercy 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<sub>4</sub> 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<sub>4</sub> 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.

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\_\_\_\_\_

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<sub>4</sub> 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 CD<sub>4</sub>), an updated genotype/phenotype lab result will need to be submitted to show continued susceptibility to Fuzeon.*

2. Please indicate current background drug therapy:

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