

FLORIDA MEDICAID PRIOR AUTHORIZATION

Fuzeon®

(Maximum Length of Approval is 6 Months)

Note: Form must be completed in full. An incomplete form may be returned.

| Recipient's Medicaid ID# | | | | | | | | | | Date of Birth (MM/DD/YYYY) | | | | | | | | | | | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-------------------------------------------|--------|-------|--------|-------|------|---------|-------|----------------------------|------------|---------------------------------|-------|-------|-------|-------|--------|--------------|-------|-------|-----------|--------|-------|-------|--------|--------|-------|------|--|
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| Recipient's Full Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Prescriber's Full Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Presc | CIT | ers | ruii i | Name | e | | | | | | | | | | | | | | | | | | | | | | | | |
| Preso | rih | or's | NDI | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Prose | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11630 | ,1110 | | | | | | | | | | Frescriber | | | | | | | 6116 | | | | | | | | | | | |
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| Pharr | nac | y Na | me | | | 1 | | 1 | | 1 | | | 1 | ı | | | | 1 | | | | ı | | | ı | | 1 | | |
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| Phari | nac | у М | edica | id P | rovid | ler# | 1 | 1 | | 1 | | | 1 | 1 | 1 | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Phari | nac | acy Phone Number | | | | | | | | | | Pharmacy F | | | | | | | | | ax Number | | | | | | | | |
| | | | - | | | | - | | | | | | | | | | | | | | - | | | | _ | | | | |
| Drug | Drug: | | | | | | | | | | | Quantity: | | | | | | | | | | | | | | | | | |
| Leng | Length of Therapy on Prescription: | | | | | | | | | | | Dosage and Frequency of Dosing: | | | | | | | | | | | | | | | | | |
| 1 | | | Initia | ation | of th | nerap | у | | 0 | R | | C | ontin | uatio | on of | the | rapy | | | | | | | | | | | | |
| 2 | | Has | the | patie | nt ha | ad a | gen | otype | e/ph | enot | ype | com | plete | ed? | (A c | ору с | of tes | st re | sults | mus | st be | sub | mitte | ed fo | r init | ial th | neraj | oy.) | |
| | | Yes No | | | | | | | | | Date: _ | | | | | | | | | | | | | | | | | | |
| 3 | . | Doe | s the | pati | ient l | have | a vi | iral lo | oad o | com | olete | d in | the | past | 6 m | onth | s? (/ | 4 <i>c</i> o | ру о | f lab | resu | ılts n | nust | be s | ubm | itted | 1.) | | |
| | | | Yes | | Γ | _ | ۷o | | | | | | | | | | | | | e: | | | | | | | - | | |
| 4 | | | | oatie | nt h | | | 1 cou | ınt c | amo | | | | | - | | | | | lab ı | | | | | | | | | |
| | | _ | Yes | | Г | | lo | | | | | | | | | 'cmn | | , | - | ə: | | | | | | | | | |
| 5 | j. | Has the patient been compliant with previ | | | | | | | evio | us th | eran | | | | | | | | | | | | | | | | | | |
| · | | | Yes | | Γ | | lo | | | 1 | | | | , . | | | | | | | | | | | | | | | |
| | | | | | _ | | - | | | | | | | | | | | | | | | | | | | | | | |
| Preso | rib | er's | Sign | ature | e: | | | | | | | Date: | | | | | | | | | | | | | | | | | |
| REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years. | | | | | | | | | | | | nt | | | | | | | | | | | | | | | | | |

Fax this form to 1-866-940-7328

Pharmacy PA Call Center:

1-855-258-1593

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Use with PA Form

Question 1 and 2 For initiation of therapy, genotype, and phenotype results should be dated within the past 12

months.

Note: Genotyping and phenotyping cannot be effectively done if the viral load is less than

1000 copies/mL. Therefore, genotyping and phenotyping is not required for those

recipients currently on Fuzeon therapy.

Question 3 Only acceptable response for approval is "Yes."

Question 4 Only acceptable response for approval is "Yes."

Question 5 New therapy requires verification of:

1) Ongoing therapy with other HIV medications

2) Compliance on previous therapies

3) Labs that demonstrate CD4 counts and antigen levels consistent with medication failure.

Continuation of therapy requires verification of compliance with other medications. If Fuzeon is working, then CD4 counts should be good and viral antigen levels should be undetectable.

Approved Indications

Fuzeon, in combination with other antiretroviral agents, is indicated for the treatment of HIV-1 infection in treatment-experienced patients with evidence of HIV-1 replication despite ongoing antiretroviral therapy.

Approval Period

Maximum of six months.