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FLORIDA MEDICAID PRIOR AUTHORIZATION

Fuzeon®

(Maximum Length of Approval is 6 Months)

FLORIDA COMMUNITY CARE

CVS caremark

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

Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY) ___ / ___ / ____

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber Phone Number ___ - ___ - ____

Prescriber Fax Number ___ - ___ - ____

Pharmacy Name

Pharmacy Medicaid Provider #

Pharmacy Phone Number ___ - ___ - ____

Pharmacy Fax Number ___ - ___ - ____

Drug: _____ **Quantity:** _____

Length of Therapy on Prescription: _____ **Dosage and Frequency of Dosing:** _____

1. ☐ Initiation of therapy **OR** ☐ Continuation of therapy
2. Has the patient had a genotype/phenotype completed? (A copy of test results must be submitted for initial therapy.)
   ☐ Yes ☐ No Date: _____
3. Does the patient have a viral load completed in the past 6 months? (A copy of lab results must be submitted.)
   ☐ Yes ☐ No _____ copies/mm^3 Date: _____
4. Has the patient had a CD4 count completed in the past 6 months? (A copy of lab results must be submitted.)
   ☐ Yes ☐ No _____ cells/cmm Date: _____
5. Has the patient been compliant with previous therapy?
   ☐ Yes ☐ No

Prescriber's Signature: _____ **Date:** _____

REQUIRED FOR REVIEW: Copies of medical records (i.e., 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.

Call or Fax Information to: Florida Community Care Prior Authorization
Phone number for non-specialty Prior Authorization: 877-433-7643
Phone number for specialty Prior Authorization: 866-814-5506
Fax number for non-specialty Prior Authorization: 866-255-7569
Fax number for non-specialty Prior Authorization: 866-249-6155

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.