FLORIDA MEDICAID PRIOR AUTHORIZATION



Fuzeon[®]





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

Recipient's Medicaid ID#										Date of Birth (MM/DD/YYYY)																				
														/				/												
Red	ipie	nt's	Full N	lame				I		I	ı	1												ı		1	1	1		
Pre	Prescriber's Full Name																													
Prescriber's NPI																														
Pre	escriber Phone Number									I	1	Prescriber Fax Number												ı						
							-															-				_				
Pharmacy Name																														
Pha	rma	ıcy N	ledica	id P	rovid	ler#		I.		ı	1	1	1	1						1	ı			1	1					
Pha	rma	су Р	cy Phone Number							1	,		Pharma					cy Fa	y Fax Number											
							-															-				-				
Dru	Prug:													_ Q	Quantity:															
Length of Therapy on Prescription:																														
	1.		Initia	tion	of th	erap	y		0	R		C	ontir	nuat	ion	of th	era	ру												
	2.	Ha	s the	patie	nt ha	ad a	gen	otyp	e/ph	enot	type	con	plet	ted?	(A	сор	y of	tes	st re	sults	mus	t be	sub	mitte	ed fo	r init	ial th	nera	oy.)	
		☐ Yes ☐ No									Date:									e:	 									
	3.	Do	es the	pat	ient l	nave	a vi	ral lo	oad (com	plete	ed in	the	pas	st 6	mor	ths	? (4	4 со	ру о	f lab	resu	ılts n	nust	be s	ubm	itted	l.)		
	☐ Yes ☐ No												cop	oies/	mm	1 ³		Dat	e:											
	4.	Ha	s the	patie	nt h	ad a	CD4	t cou	ınt c	omp	lete	d in	the	pas	t 6 r	nont	hs?	? (A	cop	y of	lab r	esul	ts m	ust l	be sı	ıbmi	tted.)		
			Yes			N	0								cel	ls/cr	nm			Dat	e:									
	5.	Ha	s the	patie	nt be	een d	com	plian	t wit	h pr	evio	us th	nera	py?																
			Yes] N	0																							
Pre	scri	ber's	Sign	ature	ə:										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

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (via return fax) immediately and arrange for the return or destruction of these documents. Distribution, reproduction or any other use of this transmission by any party other than the intended recipient is strictly prohibited.

FLORIDA® COMMUNITY CARE

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.

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.