



15 Earhart Drive, Suite 101, Amherst, NY 14221

# FUZEON AUTHORIZATION AND RE-AUTHORIZATION REQUEST

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Member Name:		Today's Date:		Date Needed:	
Date of birth:	Sex:	Weight:	Prescriber:	Hospital/Clinic:	
Home Phone Number: ( ) ( )			Phone Number: ( ) ( )	Fax Number: ( ) ( )	
Home Address:			Address:	City:	State: Zip:
Payor: <input type="checkbox"/> Independent Health <input type="checkbox"/> Anne Arundel Health System <input type="checkbox"/> Pharmacy Benefit Dimensions			<input type="checkbox"/> Commercial <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Self-funded		Office Specialty: Allergies:
Insurance ID:			Group Number:		Is patient self-injecting? <input type="checkbox"/> Yes <input type="checkbox"/> No

DRUG NAME: FUZEON	STATEMENT OF MEDICAL NECESSITY
<input type="checkbox"/> New Authorization <input type="checkbox"/> Re-Authorization*  Dose: _____ Frequency: _____ Expected duration of therapy: _____	Patient is treatment experienced as defined by:  <input type="checkbox"/> Viremia despite 3-6 months prior therapy with a nucleoside reverse transcriptase inhibitor (NRTI), non-nucleoside reverse transcriptase inhibitor (NNRTI) and protease inhibitor (PI)  <input type="checkbox"/> Viremia and documented resistance or intolerance to at least one member in each of the NRTI, NNRTI, and PI classes.  Evidence exists of viral replication despite ongoing antiretroviral therapy (at least 8 weeks on a stable regimen of antiviral combination therapy) and viral load is >5000 copies/ml with a second confirmation test. <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>
<b>*RE-AUTHORIZATION</b>	
CD4: _____ Date: _____  HIV-1 RNA: _____ Date: _____  Is patient responding to therapy? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>  Is patient tolerant and compliant with the therapeutic regimen? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>  Comments: _____ _____ _____	Patient t-cell count is <350 <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>  Recent HIV resistance test has been conducted and ARV history reviewed to determine an optimal base regimen of at least 2 active and tolerated ARVs and elimination of inactive ARVs? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>  Is patient continuing treatment with at least two antiviral agents with two different mechanisms of action? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>  Is Fuzeon being used as part of an alternative salvage regimen for a patient with end-stage disease who is at risk of serious opportunistic infections or death? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>  Does physician practice or clinic have the capacity and expertise to educate the patient regarding the preparation and administration of Fuzeon and appropriate response to the development of drug-induced adverse effects? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>  Is this request coming from an infectious disease specialist or HIV treatment specialist? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>