FORM # FRX020

Prior Authorization Request Form for Fuzeon (enfuvirtide)

Member Information

Patient Name _____

Cardholder ID _____

Date of Birth _____

Address _____

City, State Zip _____

Phone Number _____

Provider Information

Provider Name _____

DEA Number _____

Address _____

City, State and Zip _____

Phone Number _____

FAX Number _____

Pharmacy Information

Pharmacy Name_____Address_____Phone_____

Criteria for Approval:

1. Is the patient 6 years of age or older? Yes ☐ No ☐
2. Does the patient have a diagnosis of human immunodeficiency virus (HIV-1) infection? Yes ☐ No ☐
3. Is the patient currently using an optimal antiviral therapy regimen? Yes ☐ No ☐
4. Will the patient be using Fuzeon in conjunction with the optimal antiviral therapy regimen? Yes ☐ No ☐
5. Has the patient received Fuzeon therapy within the previous 6 months? Yes ☐ No ☐
6. Was there a decrease or stable virological response to the previous Fuzeon therapy? Yes ☐ No ☐
7. Is there current clinical evidence of HIV-1 replication despite ongoing antiviral therapy? Yes ☐ No ☐
8. Patient has an HIV viral load greater than or equal to 10,000 copies/ml, tested within the past 8 months while on his/her current antiretroviral regimen Yes ☐ No ☐
9. Patient's CD4 lymphocyte count is less than or equal to 350 cells/mm(3) Yes ☐ No ☐
10. Results of an HIV resistance test indicates HIV-1 virus is sensitive to 4 or fewer antiretroviral drugs Yes ☐ No ☐

Provider Signature _____ Date _____

Fax completed forms to (866) 284-4509.

For Office Use Only

Date/Time Received _____

Reference Number _____

Approved / Denied (Circle One) by _____ Date _____

Date/Time Returned to Provider _____

If you have any questions regarding this form, contact the Prior Authorization Department Toll Free at (866) 284 -4492 or Fax Toll Free at (866) 284-4509.

FOX Rx Care Utilization Management
3375-I Capital Circle NE
Tallahassee, FL 32308

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