

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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Rec	ipie	nt's	Full N	lame)					_	1																	1			
Prescriber's Full Name														ı																	
Prescriber's NPI																															
Pre	scril	criber Phone Number									,	Prescriber F										ax Number									
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Drug:																(Quai	ntity	:												
Ler	igth	of 7	Thera	ару с	on P	resc	ripti	on:		Dosage and Frequency of Dosing:																					
	1.		Initia											nuati																	
	2.	Has	s the	patie	ent ha	ad a	gen	otyp	e/ph	enot	type	com	nplet	ed?	(A co	ору (of tes	st res	sults	mus	st be	sub	mitte	ed fo	r init	ial th	neraj	oy.)			
		Has the patient had a genotype/phenotype ☐ Yes ☐ No										Date							e:												
	3.	Doe	es the	e pat	ient l	have	a vi	ral lo	oad	com	plete	ed in	the	past	6 m	onth	s? (/	4 <i>co</i>	ру 01	f lab	resu	ılts n	nust	be s	ubm	ittea	l.)				
		Yes No									copies/mm³ Date:								e:												
	4.	Has	s the	patie	ent ha	ad a	CD4	1 cou	ınt c	omp	lete	d in	the p	oast	6 mc	onths	? <i>(A</i>	сор	y of	lab r	esul	lts m	ust l	be sı	ıbmi	tted.)				
			Yes			_ N	lo							(cells	/cmn	า		Date	ə:											
	5.	5. Has the patient been compliant with previo								us th	nera	oy?																			
			Yes			_ N	lo																								
Pre	scril	ber's	Sian	atur	e:							Date:																			
REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most														ıt																	
cop	ies	of re	lated	labs	. The	prov	/ider	mus	st re	tain d	igos	es of	all	docu	ment	tatio	າ for	five	vear	s.											

Fax this form to 1-866-940-7328

Pharmacy PA Call Center: 1-800-310-6826

02.01.2025

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United Healthcare Community Plan

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nmunity Plan 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.