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# 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)** ___ / ___ / ____

**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: All copies of medical records (e.g., 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.**

**Mail or Fax Information to:**
Magellan Medicaid Administration, Inc.
Prior Authorization
P. O. Box 7082
Tallahassee, FL 32314-7082
Phone: 877-553-7481
Fax: 877-614-1078

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## 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.