

### FLORIDA MEDICAID PRIOR AUTHORIZATION

# Fuzeon<sup>®</sup>

(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	Recipient's Full Name																													
Prescriber's Full Name															<b>i</b> i															
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Drug:Quantity:																														
Length of Therapy on Prescription: Dosage and Frequency of Dosing:																														
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	☐ Yes ☐ No Date:														_															
	3.	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/mm³ Date:																													
	4.	Has	the p	oatie	nt h	ad a	CD4	4 cou	nt c	omp	lete	d in t	the p	ast	6 mc	onths	? <i>(A</i>	cop	by of	lab ı	esul	ts m	ust l	be su	ıbmi	tted.	)			
			Yes			_ N	Ю							0	cells/	/cmn	า		Date	e:										
	5. Has the patient been compliant with previous therapy?																													
			Yes			_ N	Ю																							
Pres	scrik	er's	Sign	ature	): _								Date:																	
REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent																														
		of rela																						• •						

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 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.



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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.