



Send completed form to:  
 Peach State Health Plan Pharmacy Department  
 Fax: 1-866-374-1579

## Fuzeon

### Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copy or medication delivery; please contact Peach State Health Plan at 1-800-514-0083 option # 2.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Patient's ID: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_  
 Physician's Name: \_\_\_\_\_  
 Specialty: \_\_\_\_\_ NPI#: \_\_\_\_\_  
 Physician Office Telephone: \_\_\_\_\_ Physician Office Fax: \_\_\_\_\_  
 Physician Office Address: \_\_\_\_\_

- Which drug is being prescribed?  Fuzeon, Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 Other \_\_\_\_\_
- What is the diagnosis?  Human Immunodeficiency Virus (HIV) Infection  Other \_\_\_\_\_
- What is the patient's age? \_\_\_\_\_ years
- Is the patient adherent to current antiretroviral therapy?  Yes  No
- Will Fuzeon be used in combination with other antiretroviral agents?  Yes  No
- Document **baseline** CD4+ Count: \_\_\_\_\_ cells/mm<sup>3</sup> (**Fax copy of results**)
- Document **baseline** viral load: \_\_\_\_\_ IU/ml (**Fax copy of results**)
- Is the patient currently receiving Fuzeon therapy? *If yes, skip to # 10*  Yes  No
- Does the patient have continued HIV-1 replication despite current antiretroviral therapy?  
 Yes  No

*Only answer the below questions if patient is currently receiving Fuzeon therapy*

- What date did patient start treatment? \_\_\_\_\_ (mm/dd/yyyy)
- Document **current** CD4+ Count: \_\_\_\_\_ cells/mm<sup>3</sup> (**Fax copy of results**)
- Document **current** viral load: \_\_\_\_\_ IU/ml (**Fax copy of results**)
- Has the patient shown a decrease in viremia or stable virological response?  Yes  No

**\*\*NOTE: We can NOT make a decision without a copy of the documentation - Thank You\*\***

*Information given on this form is accurate as of this date:*

X \_\_\_\_\_  
**Prescriber or Authorized Signature** **Date (mm/dd/yy)**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Centene Fuzeon - MD FAX - Update 7/1/11