PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Fuzeon® (enfuvirtide)

HEALTH PARTNERS
In Wellness and Health, Partners for Life.

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please print clearly.**

Patient Name:	**Physician Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic. Id:
Address:	Address:	
City, State, Zip:	City, State, Zip:	

Drug Name: Expedited/Urgent

Directions:

Please answer the following questions and sign below:
Q1. What is the prescriber's specialty? Board Certified Infectious Disease Specialist HIV-experienced practitioner Other
Q2. If Other, please specify:
Q3. Has the patient received and failed at least 3 to 6 months of previous antiretroviral therapy (ART) (with at least one nucleotide reverse-transcriptase inhibitor, at least one non-nucleotide reverse- transcriptase inhibitor, and at least two(2) protease inhibitors)? Yes No
Q4. Does the patient have documented resistance (based on phenotypic and genotypic resistance testing) or intolerance to at least one member in each or both classes of ART's? Yes No
Q5. Does the patient have a history of good medication adherence and regularly attends scheduled office appointments? Yes No
Q6. Deliver to: Physician's Office Home Delivery
Q7. Delivery date needed:

Physician Signature **Date**

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