



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Fuzeon® (enfuvirtide)

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 note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic ID:
Address:	Address:
City, State, Zip:	City, State, Zip:
Member Phone:	

Drug Name: Expedited/Urgent

Directions:

Patient belongs to (please check one): HEALTH PARTNERS KIDZPARTNERS

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:
Q1. What is the requested duration of therapy? 6 months or less More than 6 months
Q2. At 6 months of therapy, has the patient experienced at least = or > 1 log decrease in HIV-1 RNA (or <400 copies/ml) or have a HIV RNA below quantifiable limits to continue treatment with Fuzeon? Labs must be attached. Yes No
Q3. Comments:

Physician Signature

Date