Children's Medical Services Health Plan
OPERATED BY SUNSHINE HEALTH

Reset Form | Print Form

MEDICATION PRIOR AUTHORIZATION REQUEST FORM
FAX this completed form to 1-888-865-6531
OR Mail request to: Pharmacy Services Prior Authorization Dept.
5 River Park Place East, Suite 210 | Fresno, CA 93720
Call 1-833-705-1351 to request a 72-hour supply of medication.
Pharmacy Services will respond via fax or phone within 24 hours of receipt of all necessary information, expect during weekends and holidays. For immediate response on weekends and holidays, NurseWise will answer your call.

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.

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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.