Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Fuzeon® (enfuvirtide)

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

Health Partners Plans 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 (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP: **Specialty/facility name (if applicable):**	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the patient 6 years of age or older?

☐ Yes ☐ No

Q2. Is the prescribing physician a board certified Infectious Disease specialist or HIV-experienced practitioner?

☐ Yes ☐ No

Q3. Does the patient have a confirmed diagnosis of HIV infection? Please submit recent viral load and CD4 count?

☐ Yes ☐ No

Q4. Is the patient's diagnosis of HIV consistent with the clinical presentation of HIV-2 infection?

☐ Yes ☐ No

Q5. Does the patient have documented resistance (based on phenotypic and genotypic resistance testing) or intolerance to at least one member in each class of non-nucleotide reverse transcriptase inhibitors, nucleoside reverse transcriptase inhibitor and protease inhibitor, and co-formulated combination product?

☐ Yes ☐ No

Q6. Has the patient tried and failed at least 3 to 6 months of previous antiretroviral therapy (ART) (at least one nucleotide reverse-transcriptase inhibitor, at least one non-nucleotide reverse- transcriptase inhibitor, at least one protease inhibitors, at least one integrase inhibitor, and at least one co-formulated combination product)?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q7. Does the patient have a history of good medication adherence (information will be based on Health Partners pharmacy profile) and attend scheduled office appointments?

☐ Yes ☐ No

Q8. Additional Information:

Q9. Requested Duration:

☐ 3 months

Prescriber Signature

Date

Updated 2018