CareFirst
The CareFirst BlueCross BlueShield family of health care plans

Fuzeon® – Prior Authorization Request

Send completed form to: Case Review Unit CVS/caremark Specialty Programs Fax: 866-249-6155

CVS/caremark administers the prescription benefit plan for the patient identified. 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 to CVS/caremark toll-free at 866-249-6155**. If you have questions regarding the prior authorization, please contact CVS/caremark at **866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 800-237-2767.

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

1. What drug is being prescribed? ☐ Fuzeon® ☐ Other _____
2. What is the diagnosis?
   ☐ HIV-1 infection
   ☐ Other _____
3. What is the ICD code? _____
4. How old is the patient? _____ years
5. Has the patient received Fuzeon® greater than or equal to 6 months? *If Yes, skip to #10* ☐ Yes ☐ No
6. Please document **baseline** viral load (HIV RNA level): _____
7. Please document **baseline** CD4 count: _____ mm^3
8. Is there evidence of HIV-1 replication despite ongoing antiretroviral therapy? ☐ Yes ☐ No
9. Is Fuzeon® prescribed in combination with an optimized antiretroviral regimen? ☐ Yes ☐ No

Complete the following questions if patient is currently receiving Fuzeon®

10. Please document **current** viral load (HIV RNA level): _____
11. Please document **current** CD4 count: _____ mm^3
12. Did the patient have a positive or stable virologic response to Fuzeon®? ☐ Yes ☐ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS/caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date: (mm/dd/yy)**

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