



Prior Authorization
Fuzeon[®]
(6 Month Approval)

Beneficiary's Medicaid ID# Date of Birth (MM/DD/YYYY) / /

Beneficiary's Full Name

Prescriber's Full Name

Prescriber License # (ME, OS, RN)

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:

- Initiation of therapy OR Continuation of therapy
- Has the patient had a genotype/phenotype completed? (A copy of test results must be submitted for initial therapy.)
 No Yes Date: / / 20
- Does the patient have a viral load completed in the past 6 months? (A copy of lab results must be submitted.)
 No Yes copies/mm³ Date: / / 20
- Has the patient had a CD4 count completed in the past 6 months? (A copy of lab results must be submitted.)
 No Yes cells/cmm Date: / / 20
- Has the patient been compliant with previous therapy?
 No Yes

Prescriber's Signature: DATE:

Please attach a copy of the original prescription.

Attach lab results and other documentation as necessary. The provider must retain copies of all documentation for five years.

Fax Information to:
Clear Health Alliance
Tel: (877) 577-9044
Fax: (877) 577-9045

For CLEAR HEALTH PHARMACY Use Only			
DATE:	<input type="text"/>	NOTIFIED:	<input type="text"/>
APPROVED:	<input type="text"/>	START DATE:	<input type="text"/>
DENIAL OVERRIDE:	<input type="text"/>	EXPIRATION DATE:	<input type="text"/>
	<input type="text"/>	REASON:	<input type="text"/>