45 Earhart Drive, Suite 110, Amherst, NY 14221

FUZEON AUTHORIZATION AND RE-AUTHORIZATION

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Last Name	First Name	Today's Date	Date Needed
Parent/Guardian		Prescriber	Hospital/Clinic
Home Phone Number ( )	Work Phone Number ( )	Phone Number ( )	Fax Number ( )
Home Address	City State Zip	Address	City State Zip
Ship To: ☐ Prescriber ☐ Patient's Home Language Preference ☐ English ☐ Spanish ☐ Other		Office Contact	Prescriber Speciality
Known Allergies:		Contact Preference ☐ Phone ☐ Fax ☐ Email: ____________	
Weight _______ Lbs. Height ____ Ft _____ In	Date of Birth ____ / ___ / ____ Sex ☐ M ☐ F	Special Instructions	

INSURANCE INFORMATION

Fill out entirely or fax a copy of patient's insurance card (both sides):

Primary Insurance: ____________________
Name of Insured: ____________________
Policy #: ____________________
Group #: ____________________
Phone #: ____________________
Rx Drug Card #: ____________________

Secondary Insurance: ____________________
Name of Insured: ____________________
Policy #: ____________________
Group #: ____________________
Phone #: ____________________
Rx Drug Card #: ____________________

STATEMENT OF MEDICAL NECESSITY

CD4: ____________________ On Date: ____________

HIV-1 RNA: ____________________ On Date: ____________

Medical History: ____________________

Please list all medications patient has tried: ____________________

Please list all medications patient has developed resistance to: ____________

Is patient continuing treatment with at least two antiviral agents with two different mechanisms of action? ☐Yes ☐No

Is Fuzeon being used as part of an alternative salvage regimen for a patient with end-stage disease who is at risk of serious opportunistic infections or death? ☐Yes ☐No

Does physician practice or clinic have the capacity and expertise to educate the patient regarding the preparation and administration of Fuzeon and appropriate response to the development of drug-induced adverse effects? ☐Yes ☐No

DRUG NAME: FUZEON

☐ New Authorization ☐ Re-authorization*

Dose: ____________________

Frequency: ____________________

Expected duration of therapy: ____________________

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