

FUZEON® MEDICATION HISTORY FORM
DOCUMENTING FAILURE TO ORAL ANTI-RETROVIRAL THERAPY

Fax non-urgent requests to PerformRx Pharmacy Services at **866-369-6038** or urgent requests to **866-533-5491**. Urgent requests should be reserved for those situations in which applying the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. To speak to a representative, 866-533-5490. **Form must be completed for processing.**



Patient Name: _____ Patient ID# _____ Patient Phone _____

Patient Address: _____

Physician Name: _____ NPI # _____

Physician Address: _____

Phone # _____ Fax # _____ Contact Person _____

Is the member/patient currently residing in a Long-Term Care (LTC) facility? (please check) Yes No

(Form must be completed with all requested information in order to help establish the medical necessity of Fuzeon before utilizing all therapeutic alternatives. Failure to provide documentation may result in delays and/or denial of Fuzeon.)

	Start Date	End Date	Viral Load before treatment & lab date	CD ₄ Count before treatment & lab date	Viral Load post treatment & lab date	CD ₄ Count post treatment & lab date
1 st Drug Regimen						
2 nd Drug Regimen						
3 rd Drug Regimen						
4 th Drug Regimen						
5 th Drug Regimen						
6 th Drug Regimen						
7 th Drug Regimen						