CLEAR
HEALTH ALLIANCE

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: _____

1. ○ Initiation of therapy OR ○ Continuation of therapy
2. Has the patient had a genotype/phenotype completed? (A copy of test results must be submitted for initial therapy.)
   ○ No ○ Yes Date: ____ / ____ / 20____
3. Does the patient have a viral load completed in the past 6 months? (A copy of lab results must be submitted.)
   ○ No ○ Yes _____ copies/mm^3 Date: ____ / ____ / 20____
4. 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____
5. 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: _____ NOTIFIED: _____
APPROVED: _____ START DATE: _____ EXPIRATION DATE: _____
DENIAL OVERRIDE: _____ REASON: _____