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MAGELLAN COMPLETE CARE

Prior Authorization

Fuzeon®

Maximum Length of Approval = Six Months

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID #

Date of Birth (MM/DD/YYYY) ___ / ___ / ____

Recipient's Full Name

Prescriber's Full Name

Prescriber License # (ME, OS, ARNP, PA)

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 ○ 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: _____

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: _____

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: _____

5. Has the patient been compliant with previous therapy? ○ No ○ Yes

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

REQUIRED FOR REVIEW: Copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs. **The provider must retain copies of all documentation for five years.**

Magellan Complete Care

MCC Physician Review: ○ I do not recommend Approval. ○ I recommend Approval for _____ months.

MCC Physician Signature: _____ **Date:** _____

Fax or mail completed forms to:

Magellan Complete Care
c/o Magellan Pharmacy Solutions
11013 West Broad Street, Suite 500
Glen Allen, VA 23060

Phone: 1-800-327-8613
TTY: 1-800-424-1694
Fax: 1-800-424-7982

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