

HIV RNA TRACKING FORM WHILE RECEIVING FUZEON®

Fax to Keystone Mercy Pharmacy Services at **215-937-5018**, or to speak to a representative call **800-588-6767**. *Form must be completed for processing.*

Patient Name: _____ **Patient ID#** _____ **Patient Phone #** _____

Physician Name: _____ **NPI #** _____

Physician Address: _____

Physician Phone # _____ **Fax #** _____ **Contact Person** _____

All lab results below are necessary for initial and continuing prior authorization of Fuzeon®. Reauthorization requires updated HIV-RNA and CD4 levels as well as specific documented clinical benefits (weight gain, etc) the patient is gaining by receiving Fuzeon®. Please use “Comments” section to document any clinical improvements.

TIMEFRAME OF LEVELS	DATE OF LEVELS	HIV-RNA LEVEL	CD ₄ LEVEL	COMMENTS/OBSERVED CLINICAL IMPROVEMENTS
Baseline				
Between weeks 12 and 14 after starting therapy				
Subsequent reauthorization				

FAILURE TO SUBMIT DOCUMENTATION MAY RESULT IN DENIAL OF MEDICATION BECAUSE OF INSUFFICIENT INFORMATION.