

1 PATIENT INFORMATION

Patient's Name _____
 Date of Birth _____ Male Female Last 4 digits of SSN _____
 Street Address _____ Apt# _____
 City _____ State _____ Zip _____
 Parent/Guardian (if applicable) _____
 Home Phone _____ Work Phone _____
 Cell Phone _____ Evening Phone _____
 E-mail address _____
 Insurance Company Name _____
 Insurance Company Phone No. _____
 Insured's Name _____
 Insured's Employer _____
 Relationship to Patient _____
 Identification No. _____ Policy/Group No. _____
 Prescription Card No Yes If Yes, Carrier _____
 Policy No. _____ Group No. _____
 Is patient eligible for Medicare? No Yes **Please attach front and back copy of patient's insurance cards, if available.**

2 PRESCRIBER INFORMATION

Prescriber's Name _____
 Office Contact _____
 Clinic / Hospital Affiliation _____
 Street Address _____ Suite # _____
 City _____ State _____ Zip _____
 Phone _____ Fax _____
 NPI No. _____ License No. _____
 DEA No. _____
 Physician Medicaid UPIN No. _____
MD Specialty _____

To reach your team, call toll-free 1 888 608-9010.
Please fax completed form to the Fuzeon team
1 888 302-1028.

3 CLINICAL INFORMATION

Primary ICD-9 Code: _____
 Current Weight _____ kg/lbs Date Recorded _____
 EXPECTED DATE OF FIRST/NEXT INJECTION: _____ DATE OF LAST INJECTION (if applicable): _____
 Agency nurse to visit home for injection: Yes No
 Agency Name & Phone: _____

Rx: Fuzeon[®] (enfuvirtide)
 SIG: Inject Dose: _____ mg (Pediatrics 2mg/kg)
 Route: SC Frequency: _____
 Dispense Quantity: _____ Refills: _____
 NKDA Known Drug Allergies: _____

Deliver product to: Office Patient's Home Clinic Clinic Location

If shipped to physician's office, physician accepts on behalf of patient for administration in office

By signing below, I certify that the above therapy is medically necessary.

Prescriber's Printed Name _____
Prescriber's Signature (sign below) _____ **Date** _____

Dispense as Written

Substitution Allowed

(Physician attests this is his/her legal signature. **NO STAMPS**)