

FULYZAQ

PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

SECTION A - PATIENT INFORMATION

Today's Date:	First Name:	Last Name:
Member ID #:	Address:	
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication **NEW** or a **CONTINUATION of THERAPY** ? If so, start date: _____

Is this patient currently hospitalized? Yes No

SECTION B - PHYSICIAN INFORMATION

First Name:	Last Name:	M.D./D.O.
Address:		City: State: Zip:
Phone:	Fax:	NPI #: Specialty:

Office Contact Name / Fax Attention to: _____

Medication: _____ **Strength:** _____

Directions for use: _____

Diagnosis (Please be specific & provide as much information as possible):	ICD-10 Code:
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SECTION C - CLINICAL INFORMATION

Initial Authorization Requests:

Does the patient have a diagnosis of HIV/AIDS associated diarrhea? **Yes** **No**

Have infectious causes of diarrhea been ruled out as the cause of this patient's diarrhea? **Yes** **No**

Does this patient have persistently loose stools despite the use of anti-diarrheal medication?
 Yes **No**

Does this patient have one or more watery bowel movements per day without regular anti-diarrheal medication use? **Yes** **No**

Is this patient currently on antiretroviral therapy? **Yes** **No**
 If yes, what medications? _____

Re-Authorization Requests:

Has the patient demonstrated a positive clinical response to Fulyzaq therapy? **Yes** **No**
 Describe benefit of therapy: _____

Physician Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____

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