

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Pegylated Interferons for Hepatitis C

Complete form in its entirety and fax to:
 Prior Authorization of Benefits (PAB) Center at (866) 807- 6241

1. PATIENT INFORMATION
2. PHYSICIAN INFORMATION

Patient Name: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
Patient Phone #: _____	Physician Specialty: _____
Patient Email Address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician Email Address: _____

3. MEDICATION
4. STRENGTH
5. DURATION REQUESTED

<input type="checkbox"/> Pegasys (peg-interferon alfa-2a)	<input type="checkbox"/> 180mcg	<input type="checkbox"/> 15 Weeks (Initial treatment of Hep C Genotype 1 or 4)
<input type="checkbox"/> Peg-Intron (peg-interferon alfa-2b)	<input type="checkbox"/> 50mcg / 0.5mL	<input type="checkbox"/> 24 Weeks (Treatment of Hep C Genotype 2 or 3)
	<input type="checkbox"/> 80mcg / 0.5mL	<input type="checkbox"/> 36 Weeks (Continued treatment Genotype 1 or 4 if EVR after 12 wks)
	<input type="checkbox"/> 120mcg / 0.5mL	<input type="checkbox"/> 1 Year (Treatment of Hep C w/ribavirin contraindication)
	<input type="checkbox"/> 150mcg / 0.5mL	

6. DIAGNOSIS: _____

7. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

For Hepatitis C Genotype 1 or 4 (Initial 15 Weeks):

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient is taking ribavirin
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient has confirmed Hepatitis C (HCV)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient has detectable HCV RNA
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient had a liver biopsy
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, does liver biopsy show some fibrosis and inflammation necrosis?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If no, is liver biopsy contraindicated or not warranted by the treating physician's judgment?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient has compensated liver disease
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Treatment naïve patient
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient with significant fibrosis or cirrhosis who has received previous treatment with one of the following and demonstrated no response or has relapsed:
		<input type="checkbox"/> Non pegylated interferon monotherapy
		<input type="checkbox"/> Non pegylated interferon with ribavirin
		<input type="checkbox"/> Pegylated monotherapy
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient has received previous treatment with pegylated interferon in combination with ribavirin

PAGE 1 OF 3 – CONTINUED ON PAGE 2

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For Hepatitis C with co-infection of human immunodeficiency virus (HIV), any Genotype (1 year)

- Yes No Patient has confirmed hepatitis C (HCV) co-infected with human immunodeficiency virus (HIV)
- Yes No Patient is taking ribavirin

8. PHYSICIAN SIGNATURE

 Prescriber or Authorized Signature

 Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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PAGE 3 OF 3