PRIOR AUTHORIZATION REQUEST
Pegasys

PATIENT: Name______________________
Address: ______________________
City, State, Zip_____________________
D.O.B. _____________________
Member ID:________________________

Prescriber: Name______________________
Address ______________________
City, State, Zip_____________________
Phone _____________________
Fax _____________________
NPI _____________________

Medication Requested:____________ Qty Requested: ____________

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. ☐ Yes ☐ No Has the patient been started on Pegasys or PegIntron?
2. What is the patient's diagnosis?
   - ☐ Hepatitis C – **Please answer questions 3 - 13**
   - ☐ Indications other than Hepatitis C – Please specify ___________________________________
3. ☐ Yes ☐ No Is the patient's life expectancy less than 12 months due to non-liver related comorbidities?
4. How many weeks of therapy have been completed? NOTE: Document number of weeks and go to next question. ____
5. ☐ Yes ☐ No Does the patient have chronic hepatitis C virus (HCV) and is awaiting liver transplantation?
6. ☐ Yes ☐ No Does the patient have recurrent HCV (hepatitis C virus) post - liver transplantation?
7. ☐ Yes ☐ No Does the patient have Chronic Hepatitis C Virus (HCV)?
8. ☐ Yes ☐ No Is the patient greater than or equal to 2 years of age and less than 17 years of age?
9. ☐ Yes ☐ No Is the medication being prescribed in combination with ribavirin unless there is a contraindication or intolerance to ribavirin according to the prescriber?
10. ☐ Yes ☐ No Is the requested medication prescribed by or in consultation with one of the following prescribers who are affiliated with a liver transplant center: a gastroenterologist, hepatologist, infectious diseases physician, or liver transplant physician?
11. ☐ Yes ☐ No Is the requested medication prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or liver transplant physician?
12. ☐ Yes ☐ No Is the medication being prescribed in combination with ribavirin?
13. What is the patient's genotype for hepatitis C?
    - ☐ genotype 1
    - ☐ genotype 2
    - ☐ genotype 3

If you have any questions, call: 800-753-2851

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- ☐ genotype 4
- ☐ genotype 5
- ☐ genotype 6
- ☐ All others – Please specify ____

Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B Physician Signature

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PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

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If you have any questions, call: 800-753-2851