Fax completed form to: 1-866-868-0858
Questions, please call: 1-866-316-6049

Important Information About Prescription Drug Coverage

To: From:

Fax: Pages:

Re: Pegasys® (Peginterferon Alpha 2-a injection): Prior Authorization Request Form: Please respond.

- Please complete the attached Pegasys® (Peginterferon Alpha 2-a injection) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

Please note: By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

Information about this drug

Pegasys® (Peginterferon Alpha 2-a injection)
Alpha interferons, including Pegasys®, may cause or aggravate fatal or life-threatening neuropsychiatric, autoimmune, ischemic, and infectious disorders. Patients should be monitored closely with periodic clinical and laboratory evaluations. Pegasys® should be used cautiously in patients with a CrCl < 50ml/min, baseline neutrophil counts <1500cells/mm 3, with baseline platelet counts <90,000cells/mm 3 or baseline hemoglobin <10 g/dL.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.

MemberHealth, LLC, PO Box 391197, Solon OH 44139-3911 Last Updated: 12/13/2007

Prior Authorization Request Form

Fax completed form to 1-866-868-0858 Need help? Call 1-866-316-6049

Patient Information

Name ______________________
Member ID ______________________
Medicare ID ______________________
Date of birth ______________ Sex: M / F
Address ______________________
City ______________________
State __________ ZIP __________
Phone ______________________
Nursing home resident? YES / NO
Home care patient? YES / NO

Prescriber and Pharmacy Information

Name ______________________
Specialty ______________________
DEA ______________________
NPI ______________________
Address ______________________
City ______________________
State __________ ZIP __________
Phone __________ Fax __________

Pharmacy name ______________________
NCPDP ______________________
NPI ______________________
Phone __________ Fax __________

All items below this line are for Physician Use Only

Information for Requested Drug

Strength:________ Dosage form:______________ Qty per 30 days:__________ Drug is (circle one): Newly prescribed/Refill

Directions:______________________ Diagnosis:______________________ ICD-9 Code:__________

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

Pegasys® (Peginterferon Alpha 2-a injection) Criteria

1 Please indicate Pegasys®' dispensing location:
- ☐ the pharmacy
- ☐ the physician's supply, incident to a physician's service
- ☐ other: ....

2 Please indicate the patient's diagnosis. Select or specify the correct ICD-9 code.This question must be completed
- ☐ Chronic hepatitis B (HBeAg either positive or negative) in adults who have compensated liver disease and evidence of viral replication (detectable levels of HBV DNA) and liver inflammation (ATL> 2xULN)
- ☐ Chronic hepatitis C virus infection in adults who have compensated liver disease and have not been previously treated with interferon alpha (ICD-9: 070).
- ☐ Other (ICD-9 and diagnosis): ....

3 Is the prescribing physician a gastroenterologist, infectious disease specialist, hepatologist, transplant surgeon or has one been consulted?
☐ Yes ☐ No

4 Has the patient had a liver biopsy (unless contraindicated) demonstrating fibrosis and inflammation?
☐ Yes ☐ No

5 Does the patient have any contraindications to the use of Pegasys® (e.g., hypersensitivity to peginterferon alfa-2a or its components, autoimmune hepatitis, hepatic decompensation in cirrhotic patients (Child-Pugh score greater than 6 (class B and C)) before or during treatment, hepatic decompensation in cirrhotic chronic hepatitis C patients (Child-Pugh score greater than or equal to 6) coinfected with HIV before or during treatment, hypersensitivity to peginterferon alfa-2b or any of the components)?
☐ Yes ☐ No

Medical Justification: (Attach additional page if necessary): ______________________

Prescriber's signature:______________________ Date:______________