

Fax completed form to: 1-866-868-0858

Questions, please call: 1-866-316-6049

**TODAY'S OPTIONS®**

**Important Information About Prescription Drug Coverage**

To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

Re: PEG Intron® (Peginterferon Alpha 2-b injection): Prior Authorization Request Form: Please respond.

- Please complete the attached PEG Intron® (Peginterferon Alpha 2-b 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.

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PG 10 (6) Ap 2-b 1

Pegylated interferon in combination with ribavirin is associated with a higher virological response rates than monotherapy with pegylated interferons or ribavirin. Alpha interferons, including PEG-Intron®, 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. Patients with persistently severe or worsening signs or symptoms of these conditions should be withdrawn from therapy. In many but not all cases these disorders resolve after stopping PEG-Intron® therapy.

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.**

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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.

EG I B A b 2-b b C b

- 1 Please indicate Peg Intron's dispensing location
2 Please indicate the patient's diagnosis. Select or specify the correct ICD-9 code.
3 Is the prescribing physician a gastroenterologist, infectious disease specialist, hepatologist, transplant surgeon or has one has been consulted?
4 Has the patient had a liver biopsy (unless contraindicated) demonstrating fibrosis and inflammation?
5 Does the patient have any contraindications to the use of PEG Intron (e.g., autoimmune hepatitis (potential exacerbation), decompensated liver disease, or hypersensitivity to peginterferon alfa-2b or any of the components)?

Medical justification: (Attach additional page if necessary):

Prescriber's signature: Date: