

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: Roferon A® (interferon alpha 2-a): Prior Authorization Request Form: Please respond.

- Please complete the attached Roferon A® (interferon alpha 2-a) 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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Interferons should be used cautiously in patients with bone marrow depression, severe cardiac disease or diabetes, renal or pulmonary disease, infectious or neuropsychiatric conditions. Patients with persistently severe or worsening signs or symptoms of these conditions should be withdrawn from therapy.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 interferon alfa-2a 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.

- Please indicate Roferon®'s dispensing location:
 - pharmacy
 - physician's supply, incident to a physician's service
 - other _____
- Please indicate the patient's diagnosis. Select or specify the correct ICD-9 code. This question must be completed
 - Chronic myeloid leukemia, Chronic phase, Philadelphia chromosome positive, for patients who are minimally pretreated (within 1 year of diagnosis)(ICD-9: 205.1)
 - Hairy cell leukemia (ICD-9:202.4)
 - Hepatitis C, chronic, in patients >=18 years of age with compensated liver disease who have a history of blood or blood product exposure and/or are HCV (hepatitis C virus) antibody positive (ICD-9: 571)
 - Other (diagnosis and ICD-9): _____
- Is the prescribing physician an oncologist (leukemia diagnosis) or a gastroenterologist (hepatitis diagnosis)?
 - Yes No
- Does the patient any of the following contraindications?
 - Yes No
 - autoimmune hepatitis
 - hepatic decompensation (Child-Pugh class B and C) before or during treatment

- individuals with a known allergy to benzyl alcohol
- prior hypersensitivity to interferon alfa-2a or its components

Medical justification: (Attach additional page if necessary): _____

Prescriber's signature: _____ Date: _____