Pegasys (peginterferon alfa-2a)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ Chronic hepatitis B □ Chronic hepatitis C □ Other diagnosis: _____ICD-10:_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Prescriber's Specialty:
Is the prescriber a gastroenterologist, infectious disease physician, hepatologist, or a transplant physician?
□ Yes □ No

For <u>chronic hepatitis B</u>, answer the following:*
Does the patient have a diagnosis of either HBeAg positive or HBeAg negative chronic hepatitis B? □ Yes □ No

Does the patient have compensated liver disease? □ Yes □ No

Does the patient have evidence of viral replication and liver inflammation? □ Yes □ No
Please submit documentation supporting this information.

For <u>chronic hepatitis C</u>, also answer the following:
Select if the patient has a diagnosis of chronic hepatitis C which will be treated with one of the following therapy:
□ Monotherapy (PegIntron alone) □ Dual therapy (PegIntron and ribavirin) □ Triple therapy

<u>For monotherapy</u>:
Does the patient have a diagnosis of chronic hepatitis C which will be treated with Pegasys alone? □ Yes □ No

Does the patient have an intolerance or contraindication to ribavirin therapy? □ Yes □ No

Does the patient have a baseline (pre-treatment) HCV-RNA assessed for the diagnosis? □ Yes □ No
Please submit documentation supporting this information.

Reauthorization:
Is there at least a 2 log (100 fold) decrease in the HCV RNA level at week 12 of therapy?* □ Yes □ No
Please submit documentation supporting this information.

<u>For dual therapy</u>:
Does the patient have a baseline (pre-treatment) HCV-RNA assessed for the diagnosis?*□ Yes □ No
Please submit documentation supporting this information.
Does the patient have a diagnosis of chronic hepatitis C virus that will be treated with dual therapy (Pegasys and ribavirin only)? □ Yes □ No

Has the patient been previously treated with interferon alpha therapy? □ Yes □ No

Document the patient's genotype:* _____
Please submit documentation supporting this information.

Reauthorization:*
Document the patient's genotype: _____

Select which week of therapy the patient has completed thus far:
□ 12 weeks □ 24 weeks

Select the patient's current viral load:*
□ Detectable
□ Undetectable
□ For patients who have completed 12 weeks of therapy, less than a 2 log reduction
Please submit documentation supporting this information.

<u>For triple therapy:</u>
Select if the patient has a diagnosis of chronic hepatitis C virus that will be treated with triple therapy using the following medications:
□ Olysio □ Ribavirin □ Sovaldi

Document the patient's genotype: *_____

Does the patient have compensated liver disease?* □ Yes □ No
Please submit documentation supporting this information.

Select if the following applies to the patient:*
□ Treatment-naïve without cirrhosis
□ Null responder on prior treatment without cirrhosis
□ Relapser on prior treatment without cirrhosis
□ Cirrhosis
□ Partial responder on prior treatment without cirrhosis

Select which week of therapy the patient has completed thus far:
□ 12 weeks □ 24 weeks

Select if the patient has HCV RNA levels as follos:*
□ Undetectable at week 4
□ Undetectable at week 8
□ Undetectable at weeks 4 AND 12
□ 1,000 IU/mL or less at week 12 of treatment
□ Undetectable at week 24
Please submit documentation

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811