# PegIntron (peginterferon alfa-2b) 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.

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

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

MALE FEMALE HEIGHT (IN/CM): \_\_\_\_\_ WEIGHT (LB/KG): \_\_\_\_\_ ALLERGIES: \_\_\_\_\_

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		IF RENEWAL: DATE THERAPY INITIATED:		
DURATION OF THERAPY (SPECIFIC DATES):				

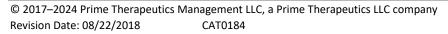
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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:			
1. HAS THE PATIENT TRIED ANY OTHER	MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) 📃 NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	<b>DURATION OF THERAPY</b> (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:		
2. LIST DIAGNOSES:		ICD-10:		
<ul> <li>Chronic hepatitis B</li> <li>Chronic hepatitis C</li> <li>Other diagnosis:</li> </ul>	ICD-10:			
<b>3. REQUIRED CLINICAL INFORMATION:</b> PRIOR AUTHORIZATION.	PLEASE PROVIDE ALL RELEVANT CLINIC	AL INFORMATION TO SUPPORT A		
Clinical Information: Has the patient had a trial and inadequate response to a 3 month trial with Pegasys?  Yes No Is the prescriber a gastroenterologist, infectious disease physician, hepatologist, or a transplant physician? Yes No				
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 an intolerance or contraindication to ribavirin therapy? <ul> <li>Yes</li> </ul>				
Does the patient have a baseline (pre-treatment) HCV-RNA assessed for the diagnosis?  Yes  No  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 compensated liver disease? <ul> <li>Yes</li> <li>No</li> </ul>				
Document the patient's genotype:*				
Document patient's baseline (pre-treatment) HCV-RNA level:* *Please submit documentation supporting this information.				
Reauthorization: Document the patient's genotype:*				
Select which week of therapy the patient has completed thus far:				





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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. For triple therapy: 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 For triple therapy with Victrelis, will dual therapy with peg-interferon and ribavirin be initiated 4 weeks before Victrelis is started? 
Ves 
No Document the patient's genotype: \* Does the patient have compensated liver disease?\* 
Ves 
No \*Please submit documentation supporting this information. **Reauthorization:** Select if Pegasys and ribavirin will be taken with the following antivirals: □ Olysio □ Sovaldi 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 Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?



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**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:

**CONFIDENTIALITY NOTICE:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

#### 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

