





**PRIOR AUTHORIZATION REQUEST FORM**

EOC ID:

**Peg-Intron with ribavirin (HEP C)**

**Phone: 215-991-4300 Fax back to: 866-240-3712**

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please print clearly.**

**Patient Name:**

**Physician Name:**

Yes    No    Not applicable
Q12. Is this request for combination therapy of Peg-Intron and ribavirin? Yes    No
Q13. Deliver to: Physician's Office    Home Delivery
Q14. Delivery date needed:

\_\_\_\_\_  
**Physician Signature**

\_\_\_\_\_  
**Date**

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