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:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic. Id:
Address:	Address:	
City, State, Zip:	City, State, Zip:	

Drug Name: Expedited/Urgent

Directions:

Please answer the following questions and sign below:
Q1. Has the patient (HCV genotype 1) received at least 3 months or 12 weeks of combination therapy? Yes No Not applicable
Q2. Have the patient's lab results been submitted, and do they show an early virologic response (EVR) being achieved (EVR defined as quantitative HCV RNA level that declined by at least 2 logs)? Yes No
Q3. Deliver to: Physician's Office Home Delivery
Q4. Delivery date needed:

Physician Signature **Date**

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