



**PRIOR AUTHORIZATION REQUEST FORM**

EOC ID:

**Pegasys 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.**

<p><b>Patient Name:</b></p> <p>Member Number:</p> <p>Date of Birth:</p> <p>Group Number:</p> <p>Address:</p> <p>City, State, Zip:</p>	<p><b>Physician Name:</b></p> <p>Fax: <span style="float:right">Phone:</span></p> <p>Office Contact:</p> <p>NPI: <span style="float:right">State Lic. Id:</span></p> <p>Address:</p> <p>City, State, Zip:</p>
---	---

Drug Name: Expedited/Urgent

Directions:

**Please answer the following questions and sign below:**

Q1. What is the requested duration of therapy?  
 4 months or less      6 months      More than 6 months

Q2. What is the patient's age?  
 Less than 18 years  
 Equal to or greater than 18 years

Q3. What is the patient's diagnosis?  
 Chronic Hepatitis C      Other

Q4. If Other, please specify:

Q5. What is the prescriber's specialty?  
 Gastroenterologist  
 Infectious Disease Specialist  
 Other

Q6. If Other, Please specify:

Q7. Have you submitted a quantitative HCV RNA and HCV genotype results for this patient?  
 Yes      No

Q8. Do the results submitted show positive for HCV genotype 1?  
 Yes      No

Q9. Do the results submitted show positive for HCV genotype other than 1 (2 or 3)?  
 Yes      No

Q10. For genotype 1 patients: Is there a liver biopsy demonstrating mild to moderate necro-inflammation and/or fibrosis ?  
 Yes      No      Not applicable

Q11. For genotype 1: Has the patient shown persistently elevated serum aminotransferase (ALT) levels?



**PRIOR AUTHORIZATION REQUEST FORM**

**EOC ID:**

**Pegasys 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 Pegasys and ribavirin? Yes    No
Q13. Deliver to: Physician's Office    Home Delivery
Q14. Delivery date needed:

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

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

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document.