



**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:**

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

**Physician Name:**

Fax:

Phone:

Office Contact:

NPI:

State Lic. Id:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

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

Q1. For genotype 1 patients: Has the patient already received at least 3 months (or 12 weeks) of combination therapy?  
Yes      No      Not applicable

Q2. Has the patient's lab results shown early virologic response (EVR) being achieved (EVR defined as quantitative HCV RNA level declined at least 2 logs)?  
Yes      No

Q3. Deliver to:  
Physician's Office      Home Delivery

Q4. Delivery date needed:

**Physician Signature**

**Date**