

UPMC HEALTH PLAN

PEGINTERFERON/INTERFERON/CHRONIC HEPATITIS C

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-979-UPMC (8762)

FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

Office Contact:		Provider Specialty: <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Hepatologist <input type="checkbox"/> Transplant <input type="checkbox"/> ID <input type="checkbox"/> Other (Please List):			
Provider First Name:		Provider Last Name:			
Provider Phone:		Provider Fax:		Provider NPI #:	
Patient Name:		Patient UPMC Health Plan ID Number:		Patient DOB:	Patient Age:
Drug Requested:	Strength:	Frequency:	Qty Dispensed:		
<input type="checkbox"/> Brand	<input type="checkbox"/> Generic				
<input type="checkbox"/> New medication	<input type="checkbox"/> Ongoing medication	If ongoing, provide date started:	If medication is ongoing, Did member show improvement while on therapy?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis:			Date of diagnosis:		
Place of infusion? (Name and Location)		<input type="checkbox"/> Physician's Office:	<input type="checkbox"/> Hospital/Facility:	Will the drug be: (select one)	
				<input type="checkbox"/> Billed directly by the provider via JCODE	
				<input type="checkbox"/> Billed by a pharmacy and delivered to the provider	
				<input type="checkbox"/> Billed by a pharmacy and delivered to the patient	
Medical History					
Please list the patient's weight _____					
Please choose the patient's race from the following					
<input type="checkbox"/> Caucasian	<input type="checkbox"/> African American	<input type="checkbox"/> Hispanic /Latino	<input type="checkbox"/> Asian	<input type="checkbox"/> Other, Please Specify _____	
Does the member have a diagnosis of Hepatitis C? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For a diagnosis other than chronic Hepatitis C, please check the following condition being treated with interferon/peginterferon:		<input type="checkbox"/> hairy cell leukemia	<input type="checkbox"/> follicular lymphoma	<input type="checkbox"/> chronic myelogenous leukemia	<input type="checkbox"/> chronic hepatitis B
		<input type="checkbox"/> Other (please specify)	<input type="checkbox"/> malignant melanoma	<input type="checkbox"/> AIDS-Related Kaposi's Sarcoma	
				<input type="checkbox"/> condylomata acuminata	
For the diagnosis of chronic hepatitis C, please include genotype:					
Please check one of the following if request is for hepatitis C:		<input type="checkbox"/> Initial treatment	<input type="checkbox"/> Continuation of treatment for genotype 1 after 12 weeks (please include current HCV RNA below)		
		<input type="checkbox"/> Retreatment	<input type="checkbox"/> Maintenance therapy		
For initial treatment, please include a baseline quantitative HCV RNA:					
For continuation of treatment after 12 weeks, please include the current quantitative HCV RNA:					
For retreatment, please include a copy of the most recent liver biopsy					
Please check any of the following chronic conditions that apply:		<input type="checkbox"/> HIV infection	<input type="checkbox"/> Renal disease (on hemodialysis)	<input type="checkbox"/> Post liver transplant	