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
Incomplete responses may delay this request.

Office Contact:	**Provider Specialty: ❑ Gastroenterologist ❑ Hepatologist ❑ Transplant ❑ ID ❑ 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: ❑ Brand ❑ Generic	**Strength:**	**Frequency:**	

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

❑ New Medication ❑ Ongoing Medication	**If Ongoing Provide Date Started:**	**If medication is ongoing, did the member show improvement while on therapy?**	❑ Yes ❑ No
Diagnosis:		**Patient Height:**	**Patient Weight:**

Please indicate place of administration:	❑ Physician's Office ❑ Hospital/Clinic
Please provide hospital/facility name and address:	**Will the drug be: (select one)** ❑ Billed directly by the provider via JCODE JCODE: _____ ❑ Billed by a pharmacy and delivered to the provider ❑ Billed by a pharmacy and delivered to the patient

MEDICAL HISTORY

Please choose the patient's race from the following
❑ Caucasian ❑ Hispanic /Latino ❑ Other, Please Specify_____
❑ African American ❑ Asian

Does the member have a diagnosis of Hepatitis C? ❑ Yes ❑ No

For a diagnosis other than chronic Hepatitis C, please check the following condition being treated with interferon/peginterferon:
❑ hairy cell leukemia
❑ follicular lymphoma
❑ chronic myelogenous leukemia
❑ chronic hepatitis B
❑ Other (please specify)
❑ malignant melanoma
❑ AIDS-Related Kaposi's Sarcoma
❑ condylomata acuminata
❑ Adjuvant treatment or melanoma

For the diagnosis of chronic hepatitis C, please include genotype:

Please check one of the following if request is for hepatitis C:
❑ Initial treatment
❑ Continuation of treatment for genotype 1 after 12 weeks (please include current HCV RNA below)
❑ Retreatment
❑ 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

Will the member be on triple therapy which includes peginterferon, ribavirin and protease inhibitor? ❑ Yes ❑ No

If no, please provide rationale:_____

Please check any of the following chronic conditions that apply:
❑ HIV infection
❑ Renal disease (on hemodialysis)
❑ Post liver transplant

Please provide any additional information which should be considered in the space below: