

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: <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:		<input type="checkbox"/> Brand <input type="checkbox"/> Generic	Strength:
			Frequency:
<i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i>			
<input type="checkbox"/> New Medication	If Ongoing Provide Date Started:	If medication is ongoing, did the member show improvement while on therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Ongoing Medication			
Diagnosis:		Patient Height:	Patient Weight:
Please indicate place of administration:	<input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Clinic	Will the drug be: (select one) <input type="checkbox"/> Billed directly by the provider via JCODE JCODE: _____	
Please provide hospital/facility name and address:		<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 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:	<input type="checkbox"/> hairy cell leukemia	<input type="checkbox"/> malignant melanoma
	<input type="checkbox"/> follicular lymphoma	<input type="checkbox"/> AIDS-Related Kaposi's Sarcoma
	<input type="checkbox"/> chronic myelogenous leukemia	<input type="checkbox"/> condylomata acuminata
	<input type="checkbox"/> chronic hepatitis B	<input type="checkbox"/> Adjuvant treatment or melanoma
	<input type="checkbox"/> Other (please specify)	

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:
