

UPMC Health Plan

PEGINTRON**, Pegasys, Intron A, and Sylatron

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"/> ID <input type="checkbox"/> Transplant <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 <input type="checkbox"/> Ongoing 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	
Diagnosis:		Patient Height:	Patient Weight:	
Please indicate place of administration:	<input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Clinic <input type="checkbox"/> Patient Home	Will the drug be: (select one) <input type="checkbox"/> Billed directly by the provider via JCODE 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		
Please provide hospital/facility name and address:				

MEDICAL HISTORY

Please indicate the diagnosis:	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Follicular Lymphoma
	<input type="checkbox"/> AIDS-Related Kaposi's Sarcoma	<input type="checkbox"/> Hairy Cell Leukemia
	<input type="checkbox"/> Chronic Hepatitis B	<input type="checkbox"/> Malignant melanoma
	<input type="checkbox"/> Chronic Myelogenous Leukemia	<input type="checkbox"/> Melanoma, adjuvant treatment
	<input type="checkbox"/> Condylomata Acuminata	
	<input type="checkbox"/> Other (please specify): _____	

FOR HEPATITIS C, PLEASE COMPLETE THE FOLLOWING:

Genotype: _____	
For Hepatitis C, please select one of the following:	<input type="checkbox"/> Initial treatment (treatment naïve)
	<input type="checkbox"/> Continuation of treatment for Genotype 1 or 4
	<input type="checkbox"/> Retreatment
	<input type="checkbox"/> Maintenance treatment
Has the member previously been treated with pegylated interferon and ribavirin? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please indicate response to peginterferon and ribavirin therapy:	
<input type="checkbox"/> Relapser.....Please provide dates of therapy: _____	
<input type="checkbox"/> Partial Responder.....Please provide dates of therapy: _____	
<input type="checkbox"/> Null Responder.....Please provide dates of therapy: _____	
For Hepatitis C Genotype 1, will the member be taking a protease inhibitor in combination with the requested product and ribavirin? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, please provide rationale: _____	

Please be sure to complete and include the 2nd page of this form.

****PEGINTRON IS THE PREFERRED PEGYLATED INTERFERON FOR UPMC HEALTH PLAN**

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Patient Name	Patient UPMC Health Plan ID #	Patient DOB:
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Please be sure to complete and include the 2nd page of this form.

FOR HEPATITIS C, PLEASE COMPLETE THE FOLLOWING:

Please indicate the intended start date of treatment with the requested product: _____

Please provide quantitative hepatitis C virus titers (HCV RNA) for the following time points in the current course of therapy:

Date of HCV RNA test:	HCV RNA Result:	Please attach chart documentation of HCV RNA results showing date, reference range, and assay. <input type="checkbox"/> Chart documentation enclosed <i>*Note: assay used to determine HCV RNA levels must have a lower limit of HCV RNA quantification of ≤ 25 IU/mL and a limit of HCV RNA detection of approximately 10-15 IU/mL*</i>
<input type="checkbox"/> Baseline:		
<input type="checkbox"/> Treatment Week 4:		
<input type="checkbox"/> Treatment Week 8:		
<input type="checkbox"/> Treatment Week 12:		
<input type="checkbox"/> Treatment Week 24:		

Does the member have compensated cirrhosis? **Yes** **No**

Please indicate if any of the following conditions apply: HIV infection
 History of liver transplant

Does the member have any of the following illnesses or conditions? (Check all that apply.)

- Autoimmune hepatitis
- Female members who are pregnant
- Male members whose female partners are pregnant
- Known hypersensitivity to drugs used to treat hepatitis C
- Decompensated liver disease

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