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:** ☐ **Gastroenterologist** ☐ **Hepatologist** ☐ **ID** ☐ **Transplant** ☐ **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** ☐ **Patient Home**	**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**
Please provide hospital/facility name and address:		

MEDICAL HISTORY

Please indicate the diagnosis:

☐ Hepatitis C
☐ AIDS-Related Kaposi's Sarcoma
☐ Chronic Hepatitis B
☐ Chronic Myelogenous Leukemia
☐ Condylomata Acuminata
☐ Follicular Lymphoma
☐ Hairy Cell Leukemia
☐ Malignant melanoma
☐ Melanoma, adjuvant treatment
☐ Other (please specify): _____

FOR HEPATITIS C, PLEASE COMPLETE THE FOLLOWING:

Genotype: _____

For Hepatitis C, please select one of the following:

☐ Initial treatment (treatment naïve)
☐ Continuation of treatment for Genotype 1 or 4
☐ Retreatment
☐ Maintenance treatment

Has the member previously been treated with pegylated interferon and ribavirin? ☐ **Yes** ☐ **No**

If yes, please indicate response to peginterferon and ribavirin therapy:

☐ Relapser……...Please provide dates of therapy: _____
☐ Partial Responder……...Please provide dates of therapy: _____
☐ 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? ☐ **Yes** ☐ **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**

PEGINTRON, Pegasys, Intron A, and Sylatron

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Patient Name	**Patient UPMC Health Plan ID #**	**Patient DOB:**

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.**
☐ Baseline:		☐ **Chart documentation enclosed**
☐ Treatment Week 4:		
☐ Treatment Week 8:		***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****
☐ Treatment Week 12:		
☐ 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: