



**Pegasys
(Interferon Alfa-2a)**

**Prior Authorization Form
Curascript
Fax (888) 773-7386**

Last Name		First Name		Prescriber's Name		Specialty	
Home Phone		Work Phone		Office Phone		Office Fax	
Home Address		City	State	ZIP	Address		City State ZIP
SCAN ID number		Date of Birth		Est. Start Date		Office Contact	
For Specialty Medications Only: Shipping Address (if different from home address) <input type="checkbox"/> Physician <input type="checkbox"/> Home				Special Instructions (i.e. Non-English Speaking Patient, etc.):			

Medication:		Diagnosis:	
Sig:	Qty:	Refills:	ICD 9 Code:

Secondary/ Supplemental Insurance Company	Phone	Name of Insured	ID Number	Group Number
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<p>1. Is this medication indicated for one of the following:</p> <ul style="list-style-type: none"> a. Treatment of adults with HBeAg positive and HBeAg negative Chronic Hepatitis B who have compensated liver disease and evidence of viral replication and liver inflammation? b. Treatment of Renal Cell Carcinoma c. Treatment of Chronic Myelogenous Leukemia
<p>2. Is this medication indicated for the treatment of adults with chronic hepatitis C virus infection who have compensated liver disease?</p>
<p>3. Has patient been previously treated with interferon alpha?</p>
<p>4. Is the prescribing physician an Infectious Disease Specialist, an Oncologist, Transplant Specialist, Nephrologist, or Gastroenterologist?</p>
<p>5. Are there any other comments, diagnoses, symptoms, and/or any other information the caller feels is important to this review?</p>

Physician's Signature: _____ NPI/DEA #: _____ Date: _____

<u>For Internal Use Only</u>	
<input type="checkbox"/> Approved	<input type="checkbox"/> Denied
Reviewer's Initials _____	Decision Date _____
Comments _____	