



Peg-Intron
(peginterferon alfa-2b)
Prior Authorization Form

Express Scripts
Phone 800-417-8164
Fax 877-837-5922

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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1. Does the patient have clinical documentation of chronic hepatitis C with compensated liver disease and detectable HCV RNA levels >50IU/ml?
2. Does the patient have previous use with interferon alpha?
3. Will Peg-Intron be used as monotherapy in patients who are intolerant to ribavirin?
4. Is the patient at least 18 years of age?
5. Will Peg-Intron be used in combination with ribavirin?
6. Is the patient 3 years of age and older?
7. Is the prescribing physician a Gastroenterologist or an Infectious Disease specialist?
8. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?

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 _____			

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information. Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at <http://www.scanhealthplan.com>.