



Peg-Intron
(peginterferon alfa-2b)

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
VH 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 detectable HCV RNA levels >50IU/ml?
2. Does the patient have previous use with interferon alpha?
3. Does the patient have liver biopsy (unless contraindicated) showing some fibrosis and inflammatory necrosis?
4. Is the prescribing physician a Gastroenterologist or an Infectious Disease specialist?
5. Is the medication being prescribed in conjunction with ribavirin?
6. What is the patient's genotype? <input type="checkbox"/> 2 or 3 <input type="checkbox"/> 1, 4, 5, or 6
7. 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: _____

For Internal Use Only <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>.