



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
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?
If yes, continue to #5. If no, continue to #3. |
| 3. Will Peg-Intron be used as monotherapy in patients who are intolerant to ribavirin?
If yes, continue to #4. If no, continue to #5. |
| 4. Is the patient at least 18 years of age?
If yes, continue to #7. If no, continue to #8. |
| 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: _____

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