



Pegasys (Interferon Alfa-2a)

Prior Authorization Form Curascript Fax (888) 773-7386

Form with fields: 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), Physician, 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

- 1. Is this medication indicated for one of the following: 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
2. Is this medication indicated for the treatment of adults with chronic hepatitis C virus infection who have compensated liver disease?
3. Has patient been previously treated with interferon alpha?
4. Is the prescribing physician an Infectious Disease Specialist, an Oncologist, Transplant Specialist, Nephrologist, or Gastroenterologist?
5. Are there any other comments, diagnoses, symptoms, and/or any other information the caller feels is important to this review?

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

For Internal Use Only: Approved, Denied, Reviewer's Initials, Decision Date, Comments