IntronA (interferon Alfa-2b)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ AIDS-related Kaposi's sarcoma □ Chronic hepatitis B □ Chronic hepatitis C □ Condylomata acuminate □ Follicular non-Hodgkin's lymphoma □ Hairy cell leukemia □ Malignant melanoma □ Relapsed/refractory advanced cutaneous T-cell lymphoma* □ Renal carcinoma □ Other diagnosis: _____ICD-10_____ **Please provide chart documentation (i.e., chart notes) supporting this information.*	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

For chronic hepatitis B, answer the following:

Does the patient have compensated liver disease? □ Yes □ No

Is Intron A prescribed by a gastroenterologist, infectious disease physician, hepatologist, or a transplant physician? □ Yes □ No

Has the patient been serum HBsAg positive for at least 6 months with evidence of HBV replication (serum HBeAg positive)?* □ Yes □ No

Does the patient have elevated serum ALT?* □ Yes □ No

Does the patient have a history of hepatic encephalopathy, variceal bleeding, ascites, or other clinical signs of decompensation? □ Yes □ No

Is the patient's bilirubin level normal?* □ Yes □ No

Are the patient's albumin levels stable and within normal limits?* □ Yes □ No

Is the patient's prothrombin time less than 3 seconds prolonged for adults or less than or equal to 2 seconds prolonged for pediatric patients?* □ Yes □ No

Is the patient's white blood count (WBC) greater than or equal to 4,000/mm³?* □ Yes □ No

Is the patient's platelet count greater than or equal to 100,000/mm³ for adults or greater than or equal to 150,000/mm³ for pediatric patients?* □ Yes □ No

****Please provide lab documentation***

For chronic hepatitis C, answer the following:
Does the patient have compensated liver disease? □ Yes □ No

Is Intron A prescribed by a gastroenterologist, infectious disease physician, hepatologist, or a transplant physician? □ Yes □ No

Does the patient have a history of hepatic encephalopathy, variceal bleeding, ascites, or other clinical signs of decompensation? □ Yes □ No

Is the patient's bilirubin level less than or equal to 2 mg/dL?* □ Yes □ No

Are the patient's albumin levels stable and within normal limits?* □ Yes □ No

Is the patient's prothrombin time less than 3 seconds prolonged?* □ Yes □ No

Is the patient's white blood count (WBC) greater than or equal to 3,000/mm³?* □ Yes □ No

Is the patient's platelet count greater than or equal to 70,000/mm³?* □ Yes □ No
Please provide lab documentation.

For condylomata acuminate, answer the following:
Is Intron A being used intralesionally? □ Yes □ No

Does the condition involve external surfaces of the genital and perianal area? □ Yes □ No

For follicular non-Hodgkin's lymphoma, answer the following:
Is Intron A being used in conjunction with anthracycline-containing chemotherapy? □ Yes □ No

For malignant melanoma, answer the following:
Is the patient free of disease but has a high risk of systemic recurrence within 56 days of surgery? □ Yes □ No

For relapsed/refractory advanced cutaneous T-cell lymphoma, answer the following:
Reauthorization:
Has the patient been tolerant of therapy and have they had a positive continued response? □ Yes □ No

For renal cell carcinoma, answer the following:
Is the patient using Intron A as monotherapy? □ Yes □ No

Is Intron A being used in combination with bevacizumab as first line therapy for relapsed or medically unresectable stage IV disease with predominant clear cell histology? □ Yes □ No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811