



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](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:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.





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

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> AIDS-related Kaposi's sarcoma <input type="checkbox"/> Chronic hepatitis B <input type="checkbox"/> Chronic hepatitis C <input type="checkbox"/> Condylomata acuminata <input type="checkbox"/> Follicular non-Hodgkin's lymphoma <input type="checkbox"/> Hairy cell leukemia <input type="checkbox"/> Malignant melanoma <input type="checkbox"/> Relapsed/refractory advanced cutaneous T-cell lymphoma* <input type="checkbox"/> Renal carcinoma <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____ <i>*Please provide chart documentation (i.e., chart notes) supporting this information.</i>		
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
<p>For chronic hepatitis B, answer the following:</p> <p>Does the patient have compensated liver disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is Intron A prescribed by a gastroenterologist, infectious disease physician, hepatologist, or a transplant physician? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the patient been serum HBsAg positive for at least 6 months with evidence of HBV replication (serum HBeAg positive)?* <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have elevated serum ALT?* <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have a history of hepatic encephalopathy, variceal bleeding, ascites, or other clinical signs of decompensation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the patient's bilirubin level normal?* <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are the patient's albumin levels stable and within normal limits?* <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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?* <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the patient's white blood count (WBC) greater than or equal to 4,000/mm³?* <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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?* <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		





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****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 acuminata, 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:** _____

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FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909

