



**PegIntron (Peginterferon 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? YES (if yes, complete below) NO

MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE): 	DURATION OF THERAPY (SPECIFY DATES): 	RESPONSE/REASON FOR FAILURE/ALLERGY:
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2. LIST DIAGNOSES: **ICD-10:**

<input type="checkbox"/> Chronic hepatitis B <input type="checkbox"/> Chronic hepatitis C <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____	
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3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:
 Has the patient had a trial and inadequate response to a 3 month trial with Pegasys? Yes No

 Is the prescriber a gastroenterologist, infectious disease physician, hepatologist, or a transplant physician? Yes No

For chronic hepatitis C, also answer the following:
 Select if the patient has a diagnosis of chronic hepatitis C which will be treated with one of the following therapy:
 Monotherapy (PegIntron alone) Dual therapy (PegIntron and ribavirin) Triple therapy

For monotherapy:*
 Does the patient have an intolerance or contraindication to ribavirin therapy? Yes No

 Does the patient have a baseline (pre-treatment) HCV-RNA assessed for the diagnosis? Yes No
**Please submit documentation supporting this information.*

Reauthorization:
 Is there at least a 2 log (100 fold) decrease in the HCV RNA level at week 12 of therapy? Yes No
**Please submit documentation supporting this information.*

For dual therapy:
 Does the patient have compensated liver disease? Yes No

Document the patient's genotype:* _____

 Document patient's baseline (pre-treatment) HCV-RNA level:* _____
**Please submit documentation supporting this information.*

Reauthorization:
 Document the patient's genotype:* _____





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Select which week of therapy the patient has completed thus far:

- 12 weeks 24 weeks

Select the patient's current viral load:*

- Detectable Undetectable
 For patients who have completed 12 weeks of therapy, less than a 2 log reduction

*Please submit documentation supporting this information.

For triple therapy:

Select if the patient has a diagnosis of chronic hepatitis C virus that will be treated with triple therapy using the following medications:

- Olysio Ribavirin Sovaldi

For triple therapy with Victrelis, will dual therapy with peg-interferon and ribavirin be initiated 4 weeks before Victrelis is started? Yes No

Document the patient's genotype: * _____

Does the patient have compensated liver disease? * Yes No

*Please submit documentation supporting this information.

Reauthorization:

Select if Pegasys and ribavirin will be taken with the following antivirals:

- Olysio Sovaldi

Select if the following applies to the patient:*

- Treatment-naïve without cirrhosis
 Null responder on prior treatment without cirrhosis
 Relapser on prior treatment without cirrhosis
 Cirrhosis
 Partial responder on prior treatment without cirrhosis

Select which week of therapy the patient has completed thus far:

- 12 weeks 24 weeks

Select if the patient has HCV RNA levels as follows:*

- Undetectable at week 4
 Undetectable at week 8
 Undetectable at weeks 4 AND 12
 1,000 IU/mL or less at week 12 of treatment
 Undetectable at week 24

*Please submit documentation

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

