



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.

			URGENI		
MEMBER INFORMATION					
LAST NAME:		FIRST NAME:			
PHONE NUMBER:		DATE OF BIRTH:			
STREET ADDRESS:					
CITY:		STATE: ZIP CODE:			
PATIENT INSURANCE ID NU	JMBER:				
MALE FEMALE HEIGHT (IN/CM): WEIGHT (LB/KG): ALLERGIES:					
OLLOWING LINK: <u>HTTPS://MAGELLANRX.C</u>	OM/MEMBER/EXTERNAL/COMMERCIAL/COMM	ON/DOC/EN-US/PHI DISCLOSURE AUTHORIZA	ATION.PDF		
PATIENT'S AUTHORIZED REI	PRESENTATIVE (IF APPLICABLE):				
	IVE'S PHONE NUMBER:				
AOTTIONIZED NEFNESENTAT	TVE 3 FITONE NOWIDER.				
PRESCRIBER INFORMATION	N .				
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	QUANTITY:		
		THERAPY/REFILLS:			
NEW THERAPY	RENEWAL	IF RENEWAL: DATE THERAPY	INITIATED:		
DURATION OF THERAPY (SE	PECIFIC DATES).				

Continued on next page.







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MEMBER'S LAST NAME:	NAME:	
1. HAS THE PATIENT TRIED ANY OTHER	R 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:
□ Chronic hepatitis B □ Chronic hepatitis C □ Other diagnosis:	ICD-10:	ICD-10:
3. REQUIRED CLINICAL INFORMATION PRIOR AUTHORIZATION.	: PLEASE PROVIDE ALL RELEVANT CLINIC	AL INFORMATION TO SUPPORT A
Clinical Information: Has the patient had a trial and inadeq	uate response to a 3 month trial with Po	egasys? □ Yes □ No
Is the prescriber a gastroenterologist, ☐ Yes ☐ No	infectious disease physician, hepatolog	ist, or a transplant physician?
· · · · · · · · · · · · · · · · · · ·	e following: chronic hepatitis C which will be treate ual therapy (PegIntron and ribavirin) 🗆	
For monotherapy:* Does the patient have an intolerance of	or contraindication to ribavirin therapy	? □ Yes □ No
Does the patient have a baseline (pre- *Please submit documentation suppor	treatment) HCV-RNA assessed for the drifting this information.	liagnosis? □ Yes □ No
Reauthorization: Is there at least a 2 log (100 fold) decre *Please submit documentation suppor	ease in the HCV RNA level at week 12 orrting this information.	f therapy?* □ Yes □ No
For dual therapy: Does the patient have compensated li	ver disease? □ Yes □ No	
Document the patient's genotype:*		
Document patient's baseline (pre-trea *Please submit documentation support	tment) HCV-RNA level:*rting this information.	
Reauthorization: Document the patient's genotype:*		
Select which week of therapy the patie	ent has completed thus far:	

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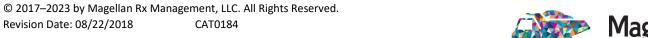






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Select the patient's current viral load:* □ Detectable □ Undetectable
 □ Detectable □ Undetectable □ For patients who have completed 12 weeks of therapy, less than a 2 log reduction
*Please submit documentation supporting this information.
For triple 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 follos:*
□ 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 mainformation is received.	ay be denied unless all required
ATTESTATION: I attest the information provided is true and accurate to the k the Health Plan, insurer, Medical Group or its designees may perform a routing information necessary to verify the accuracy of the information reported on the	ne audit and request the medical
Prescriber Signature or Electronic I.D. Verification:	Date:
CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confident you are not the intended recipient, you are hereby notified that any disclosure, copying, distril of these documents is strictly prohibited. If you have received this information in error, please and arrange for the return or destruction of these documents.	bution, or action taken in reliance on the contents

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

