PEG-INTERFERON
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information please visit *www.myprime.com*. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

☐ Standard review

☐ Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: ___________________

PATIENT AND INSURANCE INFORMATION **Date of Service (if differs from Today's Date):** ___________________

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis:

☐ Chronic hepatitis B ☐ Chronic hepatitis C

☐ Other (ICD code plus description):____

Medication Requested:	Strength:
Dosing Schedule:	Expected duration of treatment:

For all requests:

1. Is the patient currently treated with the requested agent? .... ☐ Yes ☐ No
2. How many weeks of therapy are requested? _______________
3. Has the patient been previously treated with the requested agent? .... ☐ Yes ☐ No

   If yes, how many total weeks of therapy has the patient completed?_______________
4. Does the patient have any FDA labeled contraindications to the requested agent? .... ☐ Yes ☐ No

   If yes, please specify FDA labeled contraindications:____

   ____
5. Is the patient's age within FDA labeling for the requested indication for the requested agent? .... ☐ Yes ☐ No

   If no, please provide rationale in support of using the requested agent for the patient's age for the requested indication:____

   ____

For chronic hepatitis B requests:

6. Has the chronic hepatitis B infection been confirmed by serological markers? .... ☐ Yes ☐ No

For chronic hepatitis C requests:

7. What is the patient's genotype? _________________________

   If the patient has genotype 1, please specify the subtype:______________
8. Please select the patient's treatment regimen:

   ☐ Sofosbuvir + PEG-IFN + RBV ☐ Pegasys + RBV ☐ Other (Please specify): ___________________________

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

For renewal requests:

9. Has the patient shown clinical benefit with the requested agent? .... ☐ Yes ☐ No
10. Please specify the previous therapy received and the number of weeks patient received the therapy: ___________________
____
____

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
2900 Ames Crossing Road Suite 200
Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**
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BCBSOK: 800.991.5643
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