

**Physician Request Form for Self Injectable Pegasys/Ribavirin, Peg-Intron,
Or Non Pegylated Interferons for Hepatitis C treatment**

Fax non-urgent requests to PerformRx Pharmacy Services at **877-693-8280** or urgent requests to **877-693-8476**. Urgent requests should be reserved for situations in which the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. To speak to a representative, call **800-578-0898**. *Form must be completed for processing*

Patient Name: _____ Plan ID#: _____
 Address: _____ Apt # or Suite #: _____
 City: _____ State: _____ Zip Code: _____
 Phone #: _____ Birth date: _____

Physician Name: _____ NPI #: _____
 Address: _____ Apt # or Suite #: _____
 City: _____ State: _____ Zip Code: _____
 Contact Person: _____ Phone #: _____ Fax #: _____

Physician Signature: _____ LTC member Yes No, Date Admitted _____

Deliver to: Physician's Office Patient's Home Patient filling at local Pharmacy (Name) _____

Please check if request is for Naïve Patient or Continuation of therapy.

Naïve Patient or New treatment start Start and End date of therapy: _____ to _____ Weight: _____ lb. or _____ kg
 ▪ Does the patient have a history of receiving treatment? YES NO
 ▪ If yes, please indicate medication including dates, and dosage: _____
 ▪ If yes, please indicate accordingly: NON-RESPONDER TO PREVIOUS TREATMENT RELAPSER AFTER PREVIOUS TREATMENT

Continuation Therapy - Date started: _____
 Is Member Co-infected with HIV? YES NO

For treatment-Naïve patients or New treatment starts, please submit a current (within 1 month) HCV viral titer, and AST/ALT lab results with the form or indicate below on the form. If AST/ALT are within normal limits, a liver biopsy is required to document active disease.

For continuation of therapy (treatment beyond 12 weeks), repeat HCV viral load, AST, & ALT 12 weeks after the initiation of therapy and submit lab results or indicate on form and submit pre-treatment labs or indicate on form below for reauthorization before 16 weeks after starting therapy so reauthorization is done in a timely manner.

Naïve Patients (New Treatment starts) or Pre-Treatment Labs:	Continuation of Therapy (labs after 12 weeks of therapy):
Genotype: _____ Lab Date: _____	HCV Viral Load: IU/ml _____ or Copies/ml _____ Lab Date: _____
HCV Viral Load: IU/ml _____ or Copies/ml _____ Lab Date: _____	ALT: _____ Normal range _____ Lab Date: _____
Alanine Aminotransferase (ALT): _____ Normal range _____ Lab Date: _____	AST: _____ Normal range _____ Lab Date: _____
Aspartate Aminotransferase (AST): _____ Normal range _____ Lab Date: _____	
For HIV Co-infected Members - CD4 Count _____ Lab Date: _____	
For HIV Co-infected Members - RNA Viral Load _____ Lab Date: _____	
Liver Biopsy Result or attach copy with request: _____	

Rx (please check the appropriate boxes and complete accordingly)

PEGASYS <input type="checkbox"/> 180 mcg weekly <input type="checkbox"/> Other dose and sig: _____	RIBAVIRIN 200 mg <input type="checkbox"/> 400 mg BID (<i>genotype 2&3</i>) <input type="checkbox"/> 400 mg QAM and 600 mg QPM (<i>genotype 1 or 4 & <75kg</i>) <input type="checkbox"/> 600 mg BID (<i>genotype 1 or 4 & ≥75kg</i>)
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PEG-INTRON <input type="checkbox"/> Dose and sig: _____	RIBAVIRIN 200 mg <input type="checkbox"/> Sig: _____
NON-PEGYLATED INTERFERON PRODUCT (<i>please specify requested product</i>): <input type="checkbox"/> Dose and sig: _____	RIBAVIRIN 200 mg <input type="checkbox"/> Sig: _____

If requesting a medication other than Pegasys®, please provide documentation of a medical reason for why the patient is unable to take Pegasys® to treat their medical condition (attach any necessary documentation):