



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: _____

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: _____ | Date: _____ |
| Alanine Aminotransferase (ALT): _____ Normal range _____ Lab Date: _____ | ALT: _____ Normal range _____ Lab Date: _____ |
| Aspartate Aminotransferase (AST): _____ Normal range _____ Lab Date: _____ | 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 (genotype 2&3) <input type="checkbox"/> 400 mg QAM and 600 mg QPM (genotype 1 or 4 & <75kg) <input type="checkbox"/> 600 mg BID (genotype 1 or 4 & ≥75kg) |
|---|--|

| | |
|--|--|
| PEG-INTRON <input type="checkbox"/> Dose and sig: _____ | RIBAVIRIN 200 mg <input type="checkbox"/> Sig: _____ |
| NON-PEGYLATED INTERFERON PRODUCT (please specify requested product): _____ <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):

