BlueCross BlueShield
Federal Employee Program

INTRON-A
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Intron A (interferon alfa-2b)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. What is the patient's diagnosis?

❑AIDS-related Kaposi's sarcoma ❑Condylomata acuminate ❑Hairy cell leukemia ❑Polycythemia vera
❑Carcinoid tumor ❑Follicular lymphoma ❑Malignant melanoma ❑Renal cell cancer
❑Cutaneous T-cell lymphoma (mycosis fungoides and Sezary syndrome)

❑Hepatitis C

a. Does the patient have compensated liver disease? ❑Yes ❑No

b. Is the patient an appropriate candidate for treatment with a pegylated interferon in combination with ribavirin and a protease? ❑Yes ❑No

c. Is the patient an immunosuppressed transplant recipient? ❑Yes ❑No

d. Will the patient be using Intron A in combination with Ribavirin? ***Please select answer below:***

❑ **YES: Combination therapy with Ribavirin,** please answer the following questions:

i. Is the patient's diagnosis of hepatitis C a chronic condition? ❑Yes ❑No

ii. Has the patient been previously treated with an alpha interferon? ❑Yes* ❑No

***If YES**, has the patient relapsed following alpha interferon therapy? ❑Yes ❑No

iii. Is the patient or the patient's partner pregnant? ❑Yes ❑No*

***If NO**, have patients of child bearing age been or will they be instructed to practice effective contraception during therapy and for six months after stopping ribavirin therapy? ❑Yes ❑No ❑Not of child-bearing age

iv. Has the patient been diagnosed with renal failure? ❑Yes ❑No

❑ **NO: Monotherapy *(Intron A only),*** please answer the following questions:

i. Has the patient been previously been treated with Intron A for this diagnosis? ❑Yes ❑No

ii. Has the patient's chronic hepatitis C been confirmed by liver biopsy? ❑Yes ❑No

iii. Does the patient have a history of blood or blood product exposure? ❑Yes ❑No

iv. Has the patient tested positive for antibodies to hepatitis C? ❑Yes ❑No

v. Does the patient have a significant intolerance or contraindication to ribavirin (examples include hemoglobin level below 8.5 g/dL, a hemoglobinopathy such as thalassemia major or sickle-cell anemia)? ❑Yes ❑No

vi. **FEMALE Patient**: Is the patient pregnant? ❑Yes ❑No

vii. Does the patient have a history of unstable heart disease? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ **DOB:** _____ **Patient ID: R** _____

❒ Hepatitis B

a. Has the patient previously been treated with Intron A for this diagnosis? ❒Yes ❒No

b. Is the patient's diagnosis of hepatitis B a chronic condition? ❒Yes ❒No

c. Does the patient have compensated liver disease? ❒Yes ❒No

d. Has the patient been hepatitis B surface antigen (HBsAG) positive for at least six months? ❒Yes ❒No

e. Is there current evidence of hepatitis B replication via either a positive hepatitis B e antigen (HBeAG) or a positive hepatitis B viral DNA level? ❒Yes ❒No

f. Is the patient's serum alanine aminotransferase (ALT) at least twice the upper limit? ❒Yes ❒No

g. Is the patient an immunosuppressed transplant recipient? ❒Yes ❒No

❒Other diagnosis ***(please specify):*** _____

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Intron-A – FEP MD Fax Form Revised 1/1/2019