BlueCross BlueShield Federal Employee Program

PEGINTRON
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the cardholder 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					

Instructions: Please complete only the page associated with the treatment option you are requesting.

Pegintron used as **MONOTHERAPY**	Complete **PAGE 1** only
Pegintron used with Ribavirin	Complete **PAGE 2** only

Pegintron MONOTHERAPY

(peginterferon 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?
   ❑Hepatitis C
   ❑Other diagnosis ***(please specify)***: _____
2. Will Pegintron be used in combination with ribavirin? ❑Yes ❑No
3. Has the patient undergone genotyping? ❑Yes***** ❑No
   ****If YES***, what is the patient's genotype? ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑Other: _____
4. **Genotype 1**: Has the patient been on Pegasys continuously for the last **5 months**, excluding samples? ***Select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the following question:
   a. Will an HCV viral load be drawn at treatment week 24? ❑Yes ❑No
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
   a. Did the patient have an undetectable hepatitis C viral load after 24 weeks of therapy? ❑Yes ❑No
5. Does the patient have chronic hepatitis C? ❑Yes ❑No
6. Has the patient been previously treated with interferon alpha? ❑Yes ❑No
7. Does the patient have a significant intolerance or contraindication to ribavirin or other antiviral agents? ❑Yes ❑No
8. Does the patient have a detectable viral load in the serum? ❑Yes ❑No
9. Does the patient have compensated liver disease? ❑Yes ❑No

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PEGINTRON / RIBAVIRIN PRIOR APPROVAL REQUEST

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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					

Pegintron DUAL THERAPY with Ribavirin

(peginterferon 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?
   ❑Hepatitis C
   ❑Other diagnosis ***(please specify)***: _____
2. Will Pegintron be used in combination with ribavirin? ❑Yes ❑No
3. Has the patient undergone genotyping? ❑Yes***** ❑No
   ****If YES***, what is the patient's genotype? ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑Other: _____
4. **Genotype 1**: Has the patient been on Pegasys continuously for the last **5 months**, excluding samples? ***Select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the following question:
   a. Is the patient an appropriate candidate for treatment with a protease inhibitor? ❑Yes ❑No
   b. Will an HCV viral load be drawn at treatment week 24? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
   a. Did the patient have an undetectable hepatitis C viral load after 24 weeks of therapy? ❑Yes ❑No
5. **Genotypes 2-6 or Other**: Has the patient been on Pegintron continuously for the last **4 months**, excluding samples? ❑Yes***** ❑No
   ****If YES,*** does the patient have a history of null or partial response to previous non-protease inhibitor treatment? ❑Yes ❑No
6. Does the patient have chronic hepatitis C? ❑Yes ❑No
7. **FEMALE Patient**: Please answer the following questions:
   a. Is the patient of reproductive potential? ❑Yes***** ❑No
   ****If YES***, is the patient currently pregnant? ❑Yes ❑No
   b. Will the patient be advised to use effective contraception during treatment with ribavirin and for six months after the last dose? ❑Yes ❑No

   MALE Patient: Please answer the following questions:
   a. Does the patient have a female partner of reproductive potential? ❑Yes***** ❑No
   ****If YES***, is the patient's partner currently pregnant? ❑Yes ❑No
   b. Will the patient be advised to use effective contraception during treatment with ribavirin and for six months after the last dose? ❑Yes ❑No
8. Does the patient have a detectable viral load in the serum? ❑Yes ❑No
9. Does the patient have compensated liver disease? ❑Yes ❑No

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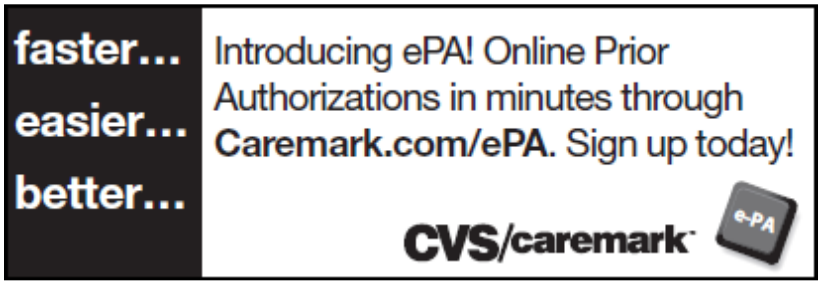
Message:

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.