



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Infergen (Medicare Determination)**

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Infergen (Medicare Determination).

Drug Name (select from list of drugs shown)

Infergen (interferon alfacon-1)

Patient Information

Patient

Name: _____

Patient ID: _____

Patient

Group No.: _____

Patient

DOB: _____

Prescribing Physician

Physician

Name: _____

Physician

Phone: _____

Physician

Fax: _____

Physician

Address: _____

City, State,

Zip: _____

Diagnosis: _____

ICD

Code: _____

Please circle the appropriate answer for each applicable question.

- | | | |
|---|---|---|
| 1. Is the physician purchasing and providing the drug "incident to" physician services? | Y | N |
| 2. Does the patient have the diagnosis of chronic hepatitis C virus infection?
[If the answer to this question is no, then no further questions are required.] | Y | N |
| 3. Is the physician aware that labeling recommends that all patients be monitored for evidence of depression? | Y | N |
| 4. Does the patient have decompensated liver cirrhosis?
[If the answer to this question is yes, then no further questions required.] | Y | N |
| 5. Has the patient received alpha interferon therapy previously?
[If the answer to this question is yes, then skip to question 8.] | Y | N |
| 6. Does the patient have detectable levels of Hepatitis C RNA (a viral load) in the serum? | Y | N |
| 7. Is the patient Genotype-1 or Genotype-4?
[Skip to question 12.] | Y | N |
| 8. Has the patient received at least 6 months of interferon therapy?
[If the answer to this question is yes, then skip to question 10.] | Y | N |
| 9. Is the patient Genotype-1 or Genotype-4? | Y | N |



Arkansas BlueCross BlueShield

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[Skip to question 11.]

10. Did the patient have detectable levels of hepatitis C virus (HCV) RNA (a viral load) in the serum after or at the end of the INITIAL treatment period? Y N

[If the answer to this question is no, then skip to question 12.]

11. Did the patient experience at least a 2-log decrease in viral load? Y N

[If the answer to this question is no, then no further questions are required.]

12. Has the patient received 12 months total of alpha interferon? Y N

Comments: _____

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date