



Prior Authorization Form

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

**Drug Name (select from list of drugs shown)**  
Peg-Intron (peginterferon alfa-2b)

**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 as evidenced by a detectable level of hepatitis C RNA (a viral load) in the serum prior to initiation of therapy?<br>[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 failure/disease?<br>[If the answer to this question is yes, then no further questions required.]  | Y | N |
| 5. Has the patient received PEGYLATED interferon (i.e., PEG-Intron or Pegasys) therapy previously?<br>[If the answer to this question is yes, then skip to question 7.]  | Y | N |
| 6. Is the patient Genotype-1 or Genotype-4?<br>[Skip to question 11.]  | Y | N |
| 7. Has the patient received at least 6 months of interferon therapy?<br>[If the answer to this question is yes, then skip to question 9.]  | Y | N |
| 8. Is the patient Genotype-1 or Genotype-4?  | Y | N |



# Arkansas BlueCross BlueShield

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[Skip to question 10.]

- |     |   |   |   |
|-----|---|---|---|
| 9.  | 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?<br>[If the answer to this question is no, then skip to question 11.] | Y | N |
| 10. | Did the patient experience at least a 2-log decrease in viral load?<br>[If the answer to this question is no, then no further questions are required.]  | Y | N |
| 11. | Has the patient received 12 months total of PEGYLATED interferon (i.e., PEG-Intron or Pegasys)?   | 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**