



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Ribavirin (Medicare Prior Authorization)**

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 Ribavirin (Medicare Prior Authorization).

Drug Name (select from list of drugs shown)

RibaPak (ribavirin tablet)	Ribasphere (ribavirin capsule)	Ribasphere Tablet (ribavirin)
Ribatab (ribavirin tablet)	Ribavirin capsule	Ribavirin tablet

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. At the initiation of therapy, did the patient have a detectable level of hepatitis C RNA (a viral load) in the serum? Y N
[If the answer to this question is no, then no further questions are required.]
2. Will the patient be using interferon alfa (e.g., Intron A, Roferon A, Pegasys, PEG-Intron) concurrently with ribavirin therapy? Y N
[If the answer to this question is no, then no further questions are required.]
3. Has the patient received up to 4 months of ribavirin therapy in the current treatment period? Y N
[If the answer to this question is no, then skip to question 6.]
4. 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 6.]
5. 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.]
6. Does the patient have a history of unstable heart disease? Y N
[If the answer to this question is yes, then no further questions are required.]
7. Does the patient have a hemoglobin value greater than 8.5 g/dL? Y N



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

8. Does the patient have a creatinine clearance greater than or equal to 50 mL/min? Y N

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

9. Has or will the patient (male or female) be instructed to practice effective contraception during therapy and for six months after stopping ribavirin therapy? Y N

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

10. Is the patient or the partner of the patient pregnant? Y N

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

11. Is the physician aware that labeling recommends that all patients be monitored for evidence of depression? Y N

12. Does the patient have the diagnosis of a hemoglobinopathy such as thalassemia major or sickle-cell anemia? Y N

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

13. Has the patient received 12 months total of combination therapy? Y N

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

14. Is the patient Genotype 1 or Genotype 4? 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