



Date of Request: _____

Sterling Retiree Rx Prior Authorization Form

INFERGEN (interferon alfacon-1)

Coverage Criteria

diagnosis of chronic hepatitis C

Required Medical Information

Prior to initiating therapy, detectable levels of HCV RNA in the serum. **Genotype 1,4:** undetectable HCV RNA after 12 weeks of treatment **or** at least 2 log decrease in HCV RNA after 12 weeks of therapy; undetectable HCV RNA after 24 weeks of treatment.

If used as **monotherapy**, patient should have a contraindication or intolerance to ribavirin.

Exclusion Criteria

Decompensated liver failure/disease; autoimmune disease; use for nonresponse or relapse.

Member Information

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

Physician Information

Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			

Requested Drug

INFERGEN	Reason for Request				
Condition/Diagnosis Related					

Clinical Drug/Lab History Pertinent to Request

Labs: Baseline/Ongoing		Strength/Dosage			
Formulary Alternative(s) Attempted?	Yes:		No:		
Please List Alternative Formulary Drugs					

Comments					
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Physicians Signature: _____

Fax Form to 1-866-481-3704