

Sterling Retiree Rx Prior Authorization Form

PEGASYS (Interferon alfa-2a)

Prescriber must be ID Specialist, Gastroenterologist or Oncologist.

Coverage Criteria / Required Medical Information

HCV: HCV genotype, detectable HCV RNA within 90 days prior to starting therapy. **Retreatment** allowed for those who did not receive optimal HCV treatment. **For reauthorization at 12 weeks, early virologic response.**

HBV: HBsAg positive or liver biopsy showing chronic hepatitis **and** appropriate HBV DNA levels for HBeAg status **and** elevated liver enzymes. Not receiving duplicate therapy. **For reauthorization, clinical improvement.**

CML: unable to tolerate tyrosine kinase inhibitors **or** post-transplant if not in remission or with relapse.

Exclusion Criteria

current psychosis or a history of psychosis; severe depression; severe thrombocytopenia; decompensated cirrhosis; serious active infection.

Coverage Duration:

Chronic Hepatitis C - 3 to 12 months total

Chronic Hepatitis B - 12 months

CML - 12 months

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

PEGASYS	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

Physician Signature: _____

Fax Form to 1-866-481-3704