

Sterling Retiree Rx Prior Authorization Form

PEGINTRON

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

PEGINTRON		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