

Date of Request: \_\_\_\_\_

## Sterling Retiree Rx Prior Authorization Form

### RIBAVIRIN, RIBASHERE, REBETOL, RIBAPAK

**Coverage Criteria / Required Medical Information**

**HCV relapse or nonresponse:** patient was initially treated with a less than optimal regimen for HCV or there is a clinical reason that suggests that patient will respond to retreatment **and** ribavirin will be used in combination with a pegylated interferon **and** this is the first time the patient is being retreated with a pegylated IFN and ribavirin.

Patient has been instructed to practice effective contraception during therapy and for six months after stopping ribavirin therapy.

**Coverage Duration**

12 weeks to a total of 72 weeks based on genotype, response, and initial vs. renewal therapy

**Exclusion Criteria**

Hgb < 8.5 g/dL; hemoglobinopathy; history of unstable heart disease; Creatinine Clearance < 50 mL/min unless the patient will receive a modified dose of ribavirin; pregnancy (self or partner).

#### Member Information

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

#### Physicians Information

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



**Sterling Retiree Rx Prior Authorization Form**

Requested Drug			
		<b>Reason for Request</b>	
<b>Condition/Diagnosis Related</b>			
Clinical Drug/Lab History Pertinent to Request			
<b>Labs: Baseline/Ongoing</b>		<b>Strength/Dosage</b>	
<b>Formulary Alternative(s) Attempted?</b>		<b>Yes:</b>	<b>No:</b>
<b>Please List Alternative Formulary Drugs</b>			
<b>Comments</b>			

**Physicians Signature:** \_\_\_\_\_ **Fax Form to 1-866-481-3704**