

INFERGEN (MEDICARE DETERMINATION)

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross[®] BlueShield[®] of South Carolina

Patient Information	
Name:	Insurance ID #:
Address:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is complete, please fax to Caremark at 888-836-0730.

This fax machine is in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 800-294-5979 with any questions concerning prior authorization procedures.

1. Is the physician purchasing and providing the drug "incident to" physician services? Y N
2. Will the patient be monitored for evidence of depression with the use of Infergen? Y N
3. Does the patient have decompensated liver failure/disease or autoimmune disease?
[If the answer to this question is yes, no further questions are required.] Y N
4. Prior to initiating therapy, does the patient have the diagnosis of chronic hepatitis C virus (HCV) infection as evidenced by detectable levels of HCV RNA (a viral load) in the serum?
[If the answer to this question is no, skip to question 20.] Y N
5. Does the prescriber have a clinical reason to use a nonpegylated interferon?
[If the answer to this question is no, no further questions are required.] Y N
6. Is Infergen prescribed as monotherapy?
[If the answer to this question is no, skip to question 8.] Y N
7. Is the patient unable to use ribavirin due to a contraindication or intolerance?
[If the answer to this question is no, no further questions are required.] Y N
[If the answer is yes, skip to question 10.]

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8. Is therapy requested for a relapse (i.e., patient is being retreated after initially responding to therapy and now virus has reappeared) or non-response of HCV treatment?
[If the answer to this question is yes, no further questions are required.] Y N
9. Is the patient Genotype-1 or Genotype-4?
[If the answer to this question is no, skip to question 13.] Y N
10. Has the patient received greater than or equal to 12 weeks of Infergen as part of an initial treatment course?
[If the answer to this question is no, no further questions are required.] Y N
11. Did the patient have detestable levels of HCV RNA in the serum after, or at the end of, the initial 12-week treatment period?
[If the answer to this question is no, skip to question 17.] Y N
12. Did the patient experience at least a 2-log decrease in viral load after the 12-week treatment period?
[If the answer to this question is yes, skip to question 15.]
[If the answer to this question is no, no further questions are required.] Y N
13. Has the patient received 12 weeks of Infergen as part of this initial treatment course?
[If the answer to this question is no, no further questions are required.] Y N
14. Has the patient received more than 24 weeks of Infergen as part of this initial treatment course?
[If the answer to this question is no, no further questions are required.] Y N
15. Has the patient received 24 weeks or more of Infergen therapy as part of this treatment course?
[If the answer to this question is no, no further questions are required.] Y N
16. Does the patient have detestable levels of HCV RNA after 24 weeks of treatment?
[If the answer to this question is yes, no further questions are required.] Y N
17. Has the patient received more than 48 weeks of Infergen therapy as part of this treatment course?
[If the answer to this question is no, no further questions are required.] Y N
18. Does the patient have Genotype 1 HCV?
[If the answer to this question is no, no further questions are required.] Y N
19. Has the patient received more than 72 weeks of Infergen therapy as part of this treatment course?
[No further questions are required.] Y N
20. Does the patient have a diagnosis of chronic hepatitis B infection evidenced by the following?
- HBeAg positive for at least six months
 - Serum HBV-DNA greater than 100,000 copies/ml or greater than 20,000 IU/mL for HBeAg positive
 - Serum HBV-DNA greater than 10,000 copies/mL or greater than 2,000 IU/mL for HBeAg negative
 - Persistent or intermittently elevated ALT greater than two times the upper limit of normal **or** liver biopsy showing chronic hepatitis with moderate or severe necroinflammation
- Y N

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Comments: _____

Information on this form is accurate as of the date below.

Prescriber's Signature:	Date:
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