

RIBASPHERE (MEDICARE DETERMINATION)

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross BlueShield of South Carolina

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

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

When this form is completed, please fax to Caremark at 1-888-836-0730.

This fax machine is located 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 1-800-294-5979 with any questions concerning prior authorization procedures.

- Does the patient have the diagnosis of chronic hepatitis C virus infection? Y N
- Will the patient be taking interferon alfa (e.g., Intron A, Roferon A, Pegasys, Peg-Intron) concurrently with ribavirin therapy? Y N
- Has the patient received ribavirin therapy previously? Y N
- Does the patient have detectable levels of Hepatitis C RNA (a viral load) in the serum? Y N
- Is the patient Genotype -1? Y N
- Does the patient have signs of chronic hepatitis on liver biopsy demonstrated by portal or bridging fibrosis, moderate inflammation, and necrosis? Y N
- Does the patient have cirrhosis of the liver as evidenced by radiological data or clinical data? Y N
- Does the patient have extrahepatic complications? Y N

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9. Has the patient received at least 6 months of interferon therapy? Y N
10. Did the patient have detectable levels of hepatitis C virus (HCV) RNA (a viral load) in the serum after or at the end of the INITIAL treatment period? Y N
11. Did the patient experience at least a 2-log decrease in viral load? Y N
12. Does the patient have a history of unstable heart disease? Y N
13. Does the patient have a hemoglobin value greater than 8.5 g/dL? Y N
14. Does the patient have a creatinine clearance greater than or equal to 50 ml/min? Y N
15. Has or will the patient (male or female) be instructed to practice effective contraception during therapy and for six months after ribavirin therapy? Y N
16. Is the patient or the partner of the patient pregnant? Y N
17. Is the physician aware that labeling recommends that all patients be monitored for evidence of depression? Y N
18. Does the patient have the diagnosis of a hemoglobinopathy such as thalassemia major or sickle-cell anemia? Y N
19. Was the patient treated for Hepatitis C infection before and has now relapsed? Y N
20. Has the patient received 12 months total of combination therapy? Y N
21. Has the patient received 18 months total of therapy? Y N

Comments: _____

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

Prescriber's Signature:	Date:
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