

RIBAVIRIN (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 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.

- At the initiation of therapy, did the patient have a detectable level of hepatitis C RNA (a viral load) in the serum?
[If the answer to this question is no, then no further questions are required.] Y N
- Will the patient be taking interferon alfa (e.g., Intron A, Roferon A, Pegasys, Peg-Intron) concurrently with Ribavirin therapy?
[If the answer to this question is no, then no further questions are required.] Y N
- Has the patient received up to 4 months of Ribavirin therapy in the current treatment period?
[If the answer to this question is not, then skip to question 6.] Y N
- 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?
[If the answer to this question is no, then skip to question 6.] Y N
- Did the patient experience at least a 2-log decrease in viral load?
[If the answer to this question is no, then no further questions are required.] Y N
- Does the patient have a history of unstable heart disease?
[If the answer to this question is yes, then no further questions are required.] Y N

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7. Does the patient have a hemoglobin value greater than 8.5 g/dL?
[If the answer to this question is no, then no further questions are required.] Y N
8. Does the patient have creatinine clearance 50 mL/min or greater?
[If the answer to this question is no, then no further questions are required.] Y N
9. Has or will the patient (male or female) be instructed to practice effective contraception during therapy and for six months after stopping Ribavirin therapy?
[If the answer to this question is no, then no further questions are required.] Y N
10. Is the patient or the partner of the patient pregnant?
[If the answer to this question is yes, then no further questions are required.] Y N
11. Is the physician aware that labeling recommends that all patients be monitored for evidence of depression? Y N
12. Does the patient have the diagnosis of hemoglobinopathy such as thalassemia major or sickle-cell anemia?
[If the answer to this question is yes, then no further questions are required.] Y N
13. Has the patient received 12 months total of combination therapy?
[If the answer to this question is yes, then no further questions are required.] Y N
14. Is the patient Genotype 1 or Genotype 4? Y N

Comments: _____

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

Prescriber's Signature:	Date:
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