



Prescription Drug Coverage Determination Form

Interferon

Infergen® (interferon alfacon-1)

Please fax the completed form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 1-800-466-9854.

Patient Information

Patient Name: _____ Date of Birth: _____
Subscriber ID#: _____
Address _____ City _____ State _____ Zip Code _____

Physician Information

Name: _____ Specialty: _____ Tax ID#: _____
Office Address _____ City _____ State _____ Zip Code _____
Telephone: _____ Fax: _____ Contact Person _____

Physician Signature (REQUIRED): _____ Date _____

Medication Information (requests for non-formulary agents will be considered for members having a documented failure or contraindication to preferred agents.)

Medication name: _____ J-code: _____
Dose: _____ Directions: _____
Expected Duration of Therapy: _____

Prior Authorization Criteria:

- 1. Is the medication being requested to treat an FDA-approved indication not otherwise excluded from Part D?
2. Does the patient have a diagnosis of chronic hepatitis C infection?
3. Does the patient have detectable levels of hepatitis C RNA (a viral load) in the serum?
4. Has the patient received at least 6 months of alpha interferon therapy previously?
5. Does the patient have compensated liver disease?

Please provide any additional history or medical information that may support coverage (attach office notes as necessary): _____

Note: If approved coverage will be as specified in above criteria or through the end of the year (December 31, 20xx). Some medications may be subject to quantity limitations or restricted to certain pharmacies.