



Prescription Drug Coverage Determination Form

Infergen

Infergen® (interferon alfacon-1)

Please fax the completed form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 1-800-647-2240.

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. Does the patient have a diagnosis of chronic hepatitis C infection?
2. Will the physician be monitoring the patient for evidence of depression?
3. Does the patient have detectable levels of hepatitis C RNA (a viral load) in the serum?
4. Is the patient Genotype-1?
5. Does the patient have signs of chronic hepatitis on liver biopsy demonstrated by portal or bridging fibrosis, moderate inflammation, and necrosis?
6. Does the patient have cirrhosis of the liver as evidence by radiological data (CT scan, ultrasound, MRI) or clinical data (e.g. variceal bleed, hypersplenism)?
7. Does the patient have extrahepatic complications?
8. Has the patient received at least 6 months of alpha interferon therapy previously?
If yes:
- Did the patient have detectable hepatitis C (HCV) RNA (a viral load) in the serum after or at the end of the initial treatment period?
- Did the patient experience a 2-log decrease in viral load?
- Was the patient treated with interferon hepatitis C in the past and has now relapsed?
- Has the patient received 12 months total of alpha interferon?
9. 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.