



Prescription Drug Coverage Determination Form
Interferon, alpha
Pegasys®

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. Is the patient 18 years of age or older? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Does the patient have the diagnosis of chronic hepatitis C virus infection? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes: | | |
| ▪ Does the patient have detectable levels of hepatitis C virus RNA in the serum? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▪ Is the patient Genotype-1? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▪ Does the patient have compensated liver disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▪ Has the patient received at least 6 months of interferon therapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 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? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▪ Did the patient experience a 2-log decrease in viral load? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▪ Was the patient treated with interferon hepatitis C in the past and has now relapsed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▪ Has the patient received 12 months total of pegylated interferon? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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|--|------------------------------|-----------------------------|
| 2. Does the patient have a diagnosis for chronic hepatitis B? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes: | | |
| ▪ Does the patient have a positive serum marker for hepatitis B (HBV) replication (e.g HBeAg+ >6 months, serum HBV-DNA >10 ⁵ copies/ml [for HBeAg+], serum HBV-DNA >>10 ⁴ copies/ml [for HBeAg-]?) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▪ Does the patient have persistently elevated aminotransferase (ALT or AST) levels greater than 2 times the upper limits of normal? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▪ Does the patient have signs of chronic hepatitis B on liver biopsy demonstrated by portal or bridging fibrosis, moderate inflammation, and necrosis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▪ 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)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▪ Does the patient have extrahepatic complications? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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.