



Prescription Drug Coverage Determination Form
Interferon
PegIntron® (peginterferon alpha-2b)

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 the diagnosis of chronic hepatitis C virus infection?
3. Does the patient have compensated liver disease?
4. Does the patient have detectable levels of hepatitis C virus RNA in the serum?
5. Has the patient received at least 6 months of interferon therapy
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?

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

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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.