

**Neighborhood Health Plan of Rhode Island  
Prior Authorization Form  
Copegus™ (Ribavirin) Tablets**

If approval criteria are met Neighborhood Health Plan of RI will authorize coverage of Copegus™ (Ribavirin) Tablets. Failure to fill out this form will result in a rejection of this medication at the pharmacy. Thank you for your assistance. Fax Number **866-423-0945**

**PLEASE COMPLETE THE FOLLOWING SECTIONS:**

Patient Name: \_\_\_\_\_ Date of Request \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Member ID#: \_\_\_\_\_ Date Of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Pt. Weight (kg): \_\_\_\_\_  
 Provider Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax#: \_\_\_\_\_

**INDICATIONS FOR USE:**

	<u>YES</u>	<u>NO</u>
1. Patient has diagnosis of chronic hepatitis C with compensated liver disease, and is receiving ribavirin tablets in combination with peginterferon alfa-2a (Pegasys®)	<input type="checkbox"/>	<input type="checkbox"/>
2. Patient is 18 years of age.	<input type="checkbox"/>	<input type="checkbox"/>
3. If this request is new or a renewal of a previous approval, please indicate if the patients most recent viral load is positive or negative by circling at the right and indicating the date of test below:	<b>Viral Load:</b> Positive or Negative	
4. <b>Therapy Start Date:</b> ____/____/____ <b>PCR Test Date:</b> ____/____/____		
5. HCV Genotype and pretreatment viral load determined and listed below: Genotype: _____ Viral Load (copies/mL): _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Prescriber is a Gastroenterologist, Infectious Disease specialist, or physician experienced in the treatment of Hepatitis C.	<input type="checkbox"/>	<input type="checkbox"/>
7. Patient maintains sobriety	<input type="checkbox"/>	<input type="checkbox"/>

**REASONS FOR BENEFIT DENIAL:**

	<u>YES</u>	<u>NO</u>
1. Patient has decompensated liver disease as diagnosed by liver biopsy or autoimmune hepatitis.	<input type="checkbox"/>	<input type="checkbox"/>
2. Patient is pregnant or may become pregnant during therapy	<input type="checkbox"/>	<input type="checkbox"/>
3. Patient has hypersensitivity to any component the product.	<input type="checkbox"/>	<input type="checkbox"/>
4. Patient has a history of unstable cardiac disease	<input type="checkbox"/>	<input type="checkbox"/>
5. Male whose partner is pregnant and <2 methods of contraception are being utilized.	<input type="checkbox"/>	<input type="checkbox"/>
6. Patient has history of hemoglobinopathies (i.e., Sickle cell anemia, Thalassemia major)	<input type="checkbox"/>	<input type="checkbox"/>
7. Patient's CrCl is < 50mL/min	<input type="checkbox"/>	<input type="checkbox"/>

**Approval will be for 6 months subject to virological response. Viral load should be measured at 0, 12 and 24 weeks to determine patient response. Approval for responders will be granted for an additional 6 months depending on genotype and viral load results.**

**Quantity Limits applied to Copegus™ for use in combination with Pegasys®:**

- **Genotypes 1, 4 and pt wt < 75kg:** 1000mg=140 tablets/28 days (4wks) for a total of 48 wks
- **Genotypes 1, 4 and pt wt ≥ 75kg:** 1200mg=168 tablets/28 days (4wks) for a total of 48 wks
- **Genotypes 2, 3:** 800mg=112 tablets/28 days (4wks) for a total of 24 wks

All information provided on this form is accurate as of this date.

\_\_\_\_\_  
Prescriber's Signature and NPI

\_\_\_\_\_  
Date