

**Neighborhood Health Plan of Rhode Island
Prior Authorization Form
Infergen® (Interferon alfacon-1)**

If approval criteria are met Neighborhood Health Plan of RI will authorize coverage of Infergen® (interferon alfacon-1). 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	<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:	Viral Load: Positive or Negative	
4. Therapy Start Date: ____/____/____ PCR Test Date: ____/____/____		
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"/>
8. If patient does not have Hepatitis C the diagnosis is a neoplastic or viral disease where the use of Infergen is supported by 2 clinical trials. Please provide references.	<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 has hypersensitivity to any component the product.	<input type="checkbox"/>	<input type="checkbox"/>

Approval will be for 6 months subject to virological response. Viral load should be measured at 0 and 16 weeks to determine patient response. Approval for partial responders will be granted in 6 months intervals up to a maximum treatment length of 48 weeks depending on genotype and viral load results.

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

 Prescriber's Signature and NPI _____
Date