

**Neighborhood Health Plan of Rhode Island
Prior Authorization Form
Intron-A® (Interferon alfa-2b)**

If approval criteria are met Neighborhood Health Plan of Rhode Island will authorize coverage of Intron-A® (interferon alfa-2b). Failure to fill out this form will result in a rejection of this medication at the pharmacy. Thank you for your assistance.

Please complete the following information:

Member Name: (required)	Member ID Number: (required) <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
Member Date of Birth: (required) / /	Member Sex: M F (Circle One)										
Prescriber Name: (required)	Contact Person at Office:										
Office Phone number: (required) () -	Office Fax Number: (required) () -										

INDICATIONS FOR USE	<u>YES</u>	<u>NO</u>
1. Patient is diagnosed with hairy-cell leukemia and is aged > 18 years	<input type="checkbox"/>	<input type="checkbox"/>
2. Patient is diagnosed with follicular lymphoma and is aged > 18 years	<input type="checkbox"/>	<input type="checkbox"/>
3. Patient is diagnosed with AIDs-related Kaposi's sarcoma and is aged > 18	<input type="checkbox"/>	<input type="checkbox"/>
4. Patient is diagnosed with malignant melanoma and is aged > 18 years Indicate if patient is also receiving surgery for the melanoma	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
5. Patient is diagnosed with chronic hepatitis B and is aged > 1 year	<input type="checkbox"/>	<input type="checkbox"/>
6. Patient is diagnosed with condylomata acuminata and is aged > 18 years Has patient used conventional therapy for condylomata acuminata, such as cryosurgery, podofilox, or imiquimod?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
7. Patient is diagnosed with a neoplastic or viral disease where the use of Intron-A is supported by 2 clinical trials. Please provide references.	<input type="checkbox"/>	<input type="checkbox"/>

BENEFIT TERMS UPON APPROVAL

Approval is as follows: Hairy cell leukemia: 6 months Malignant melanoma: 12 months Condylomata acuminata: 1 month AIDs-related Kaposi's sarcoma: 6 months Chronic HBV: 4 months Follicular lymphoma: 18 months
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All information provided on this form is accurate as of this date.

Provider _____ **Date:** _____
Signature: _____ NPI _____

Completed forms should be faxed to:
Customer Service Department
NHPRI
866-423-0945