

**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:

<b>Member Name: (required)</b>	<b>Member ID Number: (required)</b> <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> </tr> </table>								
<b>Member Date of Birth: (required)</b> /    /	<b>Member Sex:</b> M    F    (Circle One)								

<b>Prescriber Name: (required)</b>	<b>Contact Person at Office:</b>
<b>Office Phone number: (required)</b> (    ) -	<b>Office Fax Number: (required)</b> (    ) -

**INDICATIONS FOR USE**

	YES	NO
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**

<b>Approval is as follows:</b> <b>Hairy cell leukemia: 6 months</b> <b>Malignant melanoma: 12 months</b> <b>Condylomata acuminata: 1 month</b> <b>AIDs-related Kaposi's sarcoma: 6 months</b> <b>Chronic HBV: 4 months</b> <b>Follicular lymphoma: 18 months</b>
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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:**  
**Neighborhood Customer Service**  
**866-423-0945**