

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

Date of Request: _____

If approval criteria are met, Neighborhood Health Plan of Rhode Island will authorize coverage of Peg-Intron® (Pegylated 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)
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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) () -

ASSESSMENT OF BENEFIT NEED:

	YES	NO
1. Patient is diagnosed with Chronic Hepatitis C, not previously treated with pegylated interferon-alfa therapy.	<input type="checkbox"/>	<input type="checkbox"/>
2. Patient is 18 years of age and has compensated liver disease.	<input type="checkbox"/>	<input type="checkbox"/>
3. Please indicate patient's weight in kilograms:		
4. If this request is new or a renewal of a previous approval, please indicate if the patient's most recent viral load is positive or negative by circling at the right and indicating the date of test below: Therapy Start Date: ____ / ____ / ____ PCR Test Date: ____ / ____ / ____	Viral Load: Positive or Negative	
5. HCV Genotype and pretreatment viral load determined and listed below: Genotype: _____ Viral Load (viral copies/mL): _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Will patient be using in combination with oral Ribavirin tablets (Rebetol® (ribavirin) capsules)?	<input type="checkbox"/>	<input type="checkbox"/>
7. Prescriber is a Gastroenterologist, Infectious Disease specialist, or physician experienced in the treatment of hepatitis C.	<input type="checkbox"/>	<input type="checkbox"/>
8. Patient maintains sobriety	<input type="checkbox"/>	<input type="checkbox"/>

BENEFIT TERMS UPON APPROVAL:

**If patient meets criteria, initial approval will be for 3 months subject to future HCV RNA virological results. Viral load should be measured at 0, 12 and 24 weeks and patient compliance verified to determine patient response. Approval for responders will be granted for an additional 3-6 months based on genotype and viral load results.
Total length of therapy: Genotypes 2/3 =6 months (24wks); Genotype 1/4=12 months (48 wks)**

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

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

**Completed forms should be faxed to:
Neighborhood Customer Service
866-423-0945**