

**Neighborhood Health Plan of Rhode Island  
Prior Authorization Form  
Pegasys® (Pegylated Interferon alfa-2a)**

Date of Request: \_\_\_\_\_

If approval criteria are met, Neighborhood Health Plan of Rhode Island will authorize coverage of Pegasys® (Pegylated Interferon alfa-2a). 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:</b> (required)	<b>Member ID Number:</b> (required)
<b>Member Date of Birth:</b> (required) / /	<b>Member Sex:</b> M F (Circle One)

<b>Prescriber Name:</b> (required)	<b>Contact Person at Office:</b>
<b>Office Phone number:</b> (required) ( ) -	<b>Office Fax Number:</b> (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. 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:  <b>Therapy Start Date:</b> ____/____/____ <b>PCR Test Date:</b> ____/____/____	<b>Viral Load:</b> Positive or Negative	
4. HCV Genotype and pretreatment viral load determined and listed below: Genotype: _____ Viral Load (viral copies/mL): _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Will patient be using in combination with oral Ribavirin tablets (Copegus™)?	<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"/>

**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:  
Customer Service Department  
NHPRI  
866-423-0945