

**Neighborhood Health Plan of Rhode Island
Prior Authorization Form
Rebetol® (Ribavirin) Capsules and Generic Ribavirin Capsules**

If approval criteria are met Neighborhood Health Plan of Rhode Island will authorize coverage of Rebetol® (Ribavirin). 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, and is receiving ribavirin capsules in combination with interferon alfa-2b or peginterferon alfa-2b	<input type="checkbox"/>	<input type="checkbox"/>
3. Patient is 18 years of age.	<input type="checkbox"/>	<input type="checkbox"/>
4. 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: 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 (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"/>

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 is a pregnant or may become pregnant during therapy.	<input type="checkbox"/>	<input type="checkbox"/>
3. Patient has hypersensitivity to any component the product.	<input type="checkbox"/>	<input type="checkbox"/>
4. Patient has a history of unstable cardiac disease	<input type="checkbox"/>	<input type="checkbox"/>
5. Male whose partner is pregnant and <2 methods of contraception are being utilized.	<input type="checkbox"/>	<input type="checkbox"/>
6. Patient has history of hemoglobinopathies (i.e., Sickle cell anemia, Thalassemia major)	<input type="checkbox"/>	<input type="checkbox"/>
7. Patient's CrCl is < 50mL/min	<input type="checkbox"/>	<input type="checkbox"/>

Approval will be for 6 months subject to virological response. Viral load should be measured at 0, 12 and 24 weeks to determine patient response. Approval for responders will be granted for an additional 6 months depending on genotype and viral load results.

Quantity Limits:

- In combination with Peg-Intron: #112 capsules/ 28 days (4 weeks)=800mg/day
- In combination with Intron-A : #140 capsules/ 28 days (4 weeks) if patient weight ≤75kg=1000mg/day
- In combination with Intron-A : #168 capsules/ 28 days (4 weeks) if patient weight >75kg=1200mg/day

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

Prescriber's Signature and NPI

Date