

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

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. 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

	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 AIDs-related Kaposi's sarcoma and is aged > 18 years	<input type="checkbox"/>	<input type="checkbox"/>
3. Patient is diagnosed with chronic myelogenous leukemia (CML) in the chronic phase and is aged > 18 years	<input type="checkbox"/>	<input type="checkbox"/>
Indicate if patient is Philadelphia (Ph) chromosome positive	<input type="checkbox"/>	<input type="checkbox"/>
Indicate if patient has initiated treatment for CML within the last year	<input type="checkbox"/>	<input type="checkbox"/>
Indicate what therapy the patient has received if treatment was not initiated in the last year. Include dosages and dates of therapy. _____ _____ _____		
4. Patient is diagnosed with a neoplastic or viral disease where the use of Roferon-A is supported by 2 clinical trials. Please provide references.		

OR

1. Patient is diagnosed with chronic hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>
2. Can patient use Rebetron therapy if combining with ribavirin capsules?	<input type="checkbox"/>	<input type="checkbox"/>
3. Patient is 18 years of age and has compensated liver disease.	<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 (viral 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:

	YES	NO
1. Patients with autoimmune hepatitis or decompensated liver disease.	<input type="checkbox"/>	<input type="checkbox"/>
2. Patient has hypersensitivity to Intron-A or any component of the product.	<input type="checkbox"/>	<input type="checkbox"/>

Approval is as follows: Hairy cell leukemia: 6 months AIDs-related Kaposi's sarcoma: 6 months CML: 6 months	Approval for chronic hepatitis C will be for 3 months subject to virological response. Approval for responders may be given in 6 month intervals until patient has received therapy for a maximum of 12 to 18 months.
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Information given on this form is accurate as of this date.

 Prescriber's Signature and NPI

 Date

