

PEGASYS (MEDICARE DETERMINATION)

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross BlueShield of South Carolina

Patient Information	
Name:	Insurance ID #:
Group #:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is completed, please fax to Caremark at 1-888-836-0730.

This fax machine is located in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures.

1. Is the physician purchasing and providing the drug "incident to" physician services?

Note: Check guidelines at this point. If PA meets the Close As D scenario, continue with clinical questions. If not, no more questions are required and Close As B.

 Y N

2. Is the physician aware that labeling recommends that all patient be monitored for evidence of depression?

 Y N

3. Does the patient have decompensated liver failure/disease?

 Y N

4. Does the patient have the diagnosis of chronic hepatitis C virus infection?

 Y N

[if the answer to this question is no, then skip to question 13.]

5. Has the patient received PEGYLATED interferon (i.e., PEG-Intron or Pegasys) therapy previously?

 Y N

[If the answer to this question is yes, then skip to question 8.]

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MedBlue RXSM and MedBlue RX PlusSM

6. Does the patient have detectable levels of Hepatitis C RNA (a viral load) in the serum? Y N
7. Is the patient Genotype-1 or Genotype-4? Y N
 [Skip to question 12.]
8. Has the patient received at least 6 months of interferon therapy? Y N
 [If the answer to this question is yes, then skip to question 10.]
9. Is the patient Genotype-1 or Genotype-4? Y N
 [Skip to question 11.]
10. Did the patient have detectable levels of hepatitis C virus (HCV) RNA (a viral load) in the serum after or at the end of the INITIAL treatment period? Y N
 [If the answer to this question is no, then skip to question 12.]
11. Did the patient experience at least a 2-log decrease in viral load? Y N
 [If the answer to this question is no, then no further questions are required.]
12. Has the patient received 12 months total of PEGLATED intererfon (i.e., PEG-Intron or Pegasys)? Y N
 [No further questions required.]
13. Does the patient have a positive serum marker for hepatitis B (HBV) replication [serum HBV- DNA greater than 100,000 copies/mL or greater than 20,000 IU/mL (for HbeAg positive), serum HBV-DNA positive), serum HBV-DNA 2,000 IU/mL (for HbeAg negative)]? Y N
 [If the answer to this question is no, then no further questions required.]
14. Does the patient have persistently elevated serum aminotransferase (ALT or AST) levels greater than 2 times upper limits of normal? Y N
 [If the answer to this question is yes, then no further questions required.]

Confidential

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15. Does the patient have cirrhosis of the liver as evidenced by radiological data or clinical data? Y N
16. Does the patient have cirrhosis of the liver as evidenced by radiological data or clinical data?
[If the answer to this question is yes, then no further questions required.] Y N
17. Does the patient have extrahepatic complications?

Comments: _____

Information on this form is accurate as of the date below.

Prescriber's Signature:	Date:
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