

# REBETOL

## 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.

### INITIAL EVALUATION

- |  |                            |                            |
|--|----------------------------|----------------------------|
| 1. Will the patient be taking Intron A, PEG-Intron, or Pegasys concurrently with ribavirin therapy?  | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 2. Does the patient have the diagnosis of chronic hepatitis C virus infection?   | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 3. Does the patient have a history of unstable heart disease (e.g., Coronary Artery Disease-CAD, ischemic heart disease, congestive heart failure)?      | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 4. If the patient is female, is the patient pregnant?  | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 5. If the patient is male, does the patient have a partner who is pregnant?  | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 6. Has or will the patient (male or female) be instructed to practice effective contraception during therapy and for six months after ribavirin therapy? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 7. Does the patient have detectable levels of Hepatitis C RNA (a viral load) in the serum?   | <input type="checkbox"/> Y | <input type="checkbox"/> N |

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8. Does the patient have persistently elevated serum alanine aminotransferase (ALT) levels?  Y  N
9. Does the patient have signs of chronic hepatitis on liver biopsy?  Y  N
10. Does the patient have a creatinine clearance greater than or equal to 50ml/min?  Y  N
11. Will the physician monitor the patient's hemoglobin during ribavirin treatment?  Y  N
12. Is the physician aware that labeling recommends that all patients be monitored for evidence of depression?  Y  N

### RENEWAL EVALUATION

13. Will the patient be using Intron-A, PEG-Intron, or Pegasys concurrently with ribavirin therapy?  Y  N
14. Does the patient have the diagnosis of chronic Hepatitis C infection?  Y  N
15. Has the patient received at least 6 months of Hepatitis C therapy in the previous 12 months?  Y  N
16. Was the patient treated for Hepatitis C infection before and has now relapsed?  Y  N
17. Has or will the patient (male or female) be instructed to practice effective contraception during therapy and for six months after therapy with ribavirin?  Y  N
18. Did the patient have detectable levels of Hepatitis C RNA (a viral load) in the serum after or at the end of the initial treatment period?  Y  N
19. Did the patient have a normalization of serum alanine aminotransferase (ALT) during the initial treatment period?  Y  N
20. Does the patient have a hemoglobin value greater than 8.5 g/dl?  Y  N
21. Has the patient received 12 months total of combination therapy?  Y  N

**Comments:** \_\_\_\_\_

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

<b>Prescriber's Signature:</b>  	<b>Date:</b>  
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