

# ROFERON (MEDICARE DETERMINATION)

## PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross BlueShield of South Carolina

Patient Information	
Name:	Insurance ID #:
Address:	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.

When conditions are met, we will authorize the coverage of Roferon (Medicare Determination)

1. Is the patient enrolled in Medicare Part B?  Y  N
2. Has this drug claim been submitted through Medicare Part B?  Y  N
3. Was the drug claim denied by Medicare Part B?  Y  N
4. Is the drug excluded from Medicare benefit coverage (e.g., immunizations, antigens)?  Y  N
5. Is the drug delivered through intravenous administration?  Y  N
6. Is the drug administered through an implantable pump?  Y  N

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7. Is the drug administered through an external pump?  Y  N
8. Is the drug included under a local coverage policy for the applicable Medicare DMERC?  Y  N
9. Is the drug generally self-injected by a patient more than 50% of the time in an outpatient setting?  Y  N
10. Is the physician purchasing and providing the drug "incident to" physician services?  Y  N
13. Is the physician aware that labeling recommends that all patients be monitored for evidence of depression?  Y  N
14. Does the patient have a diagnosis of Hairy Cell Leukemia?  Y  N
15. Has the patient received interferon therapy previously?  Y  N
16. Did the patient have a response to interferon treatment?  Y  N
17. Does the patient have a diagnosis of Philadelphia Chromosome Positive Chronic Myelogenous Leukemia (CML)?  Y  N
18. Does the patient have the diagnosis of chronic hepatitis C?  Y  N
19. Has the patient received interferon therapy previously?  Y  N
20. Is the patient Genotype 1?  Y  N
21. Does the patient have detectable levels of hepatitis C virus (HCV) RNA (a viral load) in the serum?  Y  N
22. Does the patient have persistently elevated serum alanine aminotransferase (ALT) levels > 2 times upper limits of normal?  Y  N
23. Does the patient have signs of chronic hepatitis on liver biopsy demonstrated by portal or bridging fibrosis, moderate inflammation, and necrosis?  Y  N
24. Is the patient Genotype-1?  Y  N

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25. Did the patient receive at least 6 months of interferon therapy?  Y  N
26. Did the patient experience at least a 2-log decrease in viral load?  Y  N
27. 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
28. Did the patient have a normalization of serum alanine aminotransferase (ALT) during the initial treatment period?  Y  N
29. Was the patient treated with interferon previously and has now relapsed?  Y  N
30. Is the patient to be treated with interferon monotherapy?  Y  N
31. Has the patient received 24 months of total therapy?  Y  N
32. Has the patient received 12 months of total 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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