FORM # FRX019

Prior Authorization Request Form for Intron A/Infergen

Member Information

Patient Name _____

Cardholder ID _____

Date of Birth _____

Address _____

City, State Zip _____

Phone Number _____

Provider Information

Provider Name _____

DEA Number _____

Address _____

City, State and Zip _____

Phone Number _____

FAX Number _____

Pharmacy Information

Pharmacy Name_____Address_____Phone_____

Drug Name and Strength_____

Criteria for Approval:

1. Does the patient have a diagnosis of: *Check all that apply:*
   - ☐ AIDS-related Kaopsi's Sarcoma
   - ☐ Chronic Hepatitis B
   - ☐ Chronic Hepatitis C
   - ☐ Condyloma acuminatum (genital warts)
   - ☐ Follicular Non-Hodgkin's Lymphoma
   - ☐ Hairy Cell Leukemia
   - ☐ Malignant Melanoma
2. Has the patient received interferon therapy within the previous year? Yes ☐ No ☐
3. Did the patient respond to the previous interferon therapy? Yes ☐ No ☐
4. Did the patient have detectable serum levels of hepatic C virus (HCV) RNA after or at the end of initial treatment with an interferon? Yes ☐ No ☐
5. Does the patient have: *Check all that apply:*
   - ☐ Detectable levels of hepatits C virus (HBV) RNA in the serum
   - ☐ Serum markers of hepatitis B virus (HBV) replication (HBeAg and HBV DNA)
   - ☐ Demonstrated chronic hepatitis C on liver biopsy
   - ☐ Persistently elevated serum alanine aminotransferase (ALT) levels > 2 times the upper limit
   - ☐ A viral load of at least > 2-log decrease
6. Is the patient Genotype-1? Yes ☐ No ☐
7. Will Intron A be used in conjunction with anthracycline containing chemotherapy? Yes ☐ No ☐
8. Will the patient be monitored for depression during therapy? Yes ☐ No ☐
9. Will the hemoglobin levels be monitored during therapy? Yes ☐ No ☐
10. Is the patient being treated for relapse after monotherapy with an interferon product? Yes ☐ No ☐
11. If the patient has relapsed or did not respond to previous interferon therapy, will the patient be restarted on a higher dose regimen as labeling recommends? Yes ☐ No ☐

Provider Signature _____ Date _____

Fax completed forms to (866) 284-4509.

For Office Use Only

Date/TimeReceived_____

ReferenceNumber_____

Approved / Denied (Circle One) by _____ Date_____

Date/Time Returned to Provider_____

If you have any questions regarding this form, contact the Prior Authorization Department Toll Free at (866) 284-4492 or Fax Toll Free at (866) 284-4509.

FOX Rx Care Utilization Management
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Tallahassee, FL 32308

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