FORM # FRX027

Prior Authorization Request Form for Rebetron (ribavirin oral capsule and interferon alfa-2b, recombinant injection)

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_____

Criteria for Approval:

1. Does the patient have a diagnosis of chronic hepatitis C with signs present and demonstrated on liver biopsy? Yes ☐ No ☐
2. Does the patient have a history of heart disease? Yes ☐ No ☐
3. Does the patient have: *Check all that apply:*
   Hemoglobin > 8.5 gm/dL ☐ Creatinine clearance ≥ 50 ml/min/1.73m² ☐
4. Does the patient have: *Check all that apply:*
   Detectable levels of hepatitis C virus (HCV) RNA in the serum ☐
   Persistently elevated serum alanine aminotransferase (ALT) levels > 2 times the upper limit Detectable levels of hepatits C virus (HBV) RNA in the serum ☐
5. 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 ☐
6. Is the patient Genotype-1? Yes ☐ No ☐
7. Is the patient: *Check one:*
   Female and pregnant or planning to become pregnant ☐
   Male with a partner that is pregnant or planning to become pregnant ☐
8. Has or will the patient be instructed to practice effective contraceptives during therapy and six months after therapy with ribavirin? Yes ☐ No ☐
9. Has the patient received interferon therapy within the previous year? Yes ☐ No ☐
10. Did the patient respond to the previous interferon therapy? Yes ☐ No ☐
11. Will the patient be monitored for depression during therapy? Yes ☐ No ☐
12. Will the hemoglobin levels be monitored during therapy? Yes ☐ No ☐
13. Is the patient being treated for relapse after monotherapy with an interferon product? Yes ☐ No ☐
14. Will the patient be using Intron A or Pegasys with rebavirin therapy? Yes ☐ No ☐

Provider Signature _____ Date _____

Fax completed forms to (866) 284-4509.

For Office Use Only Date/TimeReceived_____

Reference Number_____

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 CareUtilization Management
3375-I Capital Circle NE
Tallahassee, FL 32308

IMPORTANT NOTICE: This facsimile is intended to be delivered to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure and applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by other than the named addressee, except by express authority of the sender to the named addressee.

FOX Rx Care
We take your coverage personally.