

**Physician Request Form for Self Injectable Pegasys/Ribavirin, Peg-Intron,
Or Non Pegylated Interferons for Hepatitis C treatment**

Fax non-urgent requests to PerformRx Pharmacy Services at 866-639-6038 or urgent requests to 866-533-5491. Urgent requests should be reserved for those situations in which applying the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function.

To speak to a representative, call **866-533-5490**. *Form must be completed for processing.*



Patient Name: _____

Plan ID#: _____

Address: _____

Apt # or Suite #: _____

City: _____ State: _____

Zip Code: _____

Phone #: _____

Birth date: _____

Physician Name: _____

NPI #: _____

Address: _____

Apt # or Suite #: _____

City: _____ State: _____

Zip Code: _____

Contact Person: _____ Phone #: _____

Fax #: _____

Physician Signature: _____

Deliver to: Physician's Office Patient's Home Patient filling at local Pharmacy (Name) _____ Fax: _____

Is the member/patient currently residing in a Long-Term Care (LTC) facility? (please check) Yes No

Please check if request is for Naive Patient or continuation of therapy.

Naive Patient or New treatment start Start and End date of therapy: _____ to _____ Weight: _____ lb. or _____ kg

▪ Does the patient have a history of receiving treatment? YES NO

▪ If yes, please indicate medication including dates, and dosage: _____

▪ If yes, please indicate accordingly: NON-RESPONDER TO PREVIOUS TREATMENT RELAPSER AFTER PREVIOUS TREATMENT

Continuation Therapy - Date started: _____

Is Member Co-infected with HIV? YES NO

For treatment-Naive patients or New treatment starts, please submit a current (within 1 month) HCV viral titer, and AST/ALT lab results with the form or indicate below on the form. If AST/ALT are within normal limits, a liver biopsy is required to document active disease.

For continuation of therapy (treatment beyond 12 weeks), repeat HCV viral load, AST, & ALT 12 weeks after the initiation of therapy and submit lab results or indicate on form and submit pre-treatment labs or indicate on form below for reauthorization before 16 weeks after starting therapy so reauthorization is done in a timely manner.

Naive Patients or New Treatment starts (Pre-Treatment Labs):

Genotype: _____ Lab Date: _____
 HCV Viral Load: IU/ml _____ or Copies/ml _____ Lab Date: _____
 Alanine Aminotransferase (ALT): _____ Normal range _____ Lab Date: _____
 Asparate Aminotransferase (AST): _____ Normal range _____ Lab Date: _____
 For HIV Co-infected Members - CD4 Count _____ Lab Date: _____
 For HIV Co-infected Members - RNA Viral Load _____ Lab Date: _____
 Liver Biopsy Result or attach copy with request: _____

Continuation of Therapy (labs after 12 weeks of therapy):

HCV Viral Load: IU/ml _____ or Copies/ml _____ Lab Date: _____
 Alanine Aminotransferase (ALT): _____ Normal range _____ Lab Date: _____
 Asparate Aminotransferase (AST): _____ Normal range _____ Lab Date: _____
Pre-Treatment Labs - labs done before starting therapy:
 HCV Viral Load: IU/ml _____ or Copies/ml _____ Lab Date: _____
 Alanine Aminotransferase (ALT): _____ Normal range _____ Lab Date: _____
 Asparate Aminotransferase (AST): _____ Normal range _____ Lab Date: _____

Rx (please check the appropriate boxes and complete accordingly)

<p>PEGASYS</p> <p><input type="checkbox"/> 180 mcg weekly</p> <p><input type="checkbox"/> Other dose and sig: _____</p>	<p>PEG-INTRON</p> <p>Dose and sig: _____</p>
<p>RIBAVIRIN 200 mg</p> <p><input type="checkbox"/> 400 mg BID (<i>genotype 2&3</i>)</p> <p><input type="checkbox"/> 400 mg QAM and 600 mg QPM (<i>genotype 1, <75kg</i>)</p> <p><input type="checkbox"/> 600 mg BID (<i>genotype 1, ≥75kg</i>)</p>	

NON-PEGYLATED INTERFERON PRODUCTS (please specify requested product and directions)

Rx: _____ Sig: _____

Ribavirin 200 mg (*if applicable*) Sig: _____

Additional Comments: _____

Key Points from the current guidelines for the treatment of Hepatitis C:

- ❖ **Viral load should be checked after 12 weeks of therapy:** An early virological response (EVR), defined as at least a two-log decrease in a patient's viral load, is an important predictor of successful therapy. Patients who do not have an EVR at 12 weeks are less (3.1% chance) likely to clear the virus and have a sustained viral response. Continuation of therapy is not recommended for most patients.

Appropriate length of treatment: When using a peg-interferon product in combination with ribavirin, patients with genotype 1 and all HIV patients regardless of genotype should be treated for 48 weeks while patients with genotypes 2 and 3 should be treated for 24 weeks. Treating a patient with genotype 2 or 3 beyond 24 weeks is not recommended and would be considered investigational, except for members that are co-infected with HIV, treatment up to 48 weeks is appropriate.