

# Network Health Prior Authorization Request for Hepatitis C Medications

**Medication Request Form (MRF)**

**FAX TO: (877) 501-1059**

**c/o MedImpact Healthcare Systems, Inc.**

Attn: Prior Authorization Department

10680 Treena Street, Suite 500, San Diego, CA 92131 - Phone: 1-800-788-2949

**Pegasys, PegIntron, Infergen,**

**Copegus, Rebetol, Ribavirin**

**Instructions:**

This form is to be used by participating providers to obtain coverage for the drugs listed above, which require prior authorization. Please complete this form and fax it to MedImpact Healthcare Systems, Inc. at (877) 501-1059. If you have any questions regarding this process, please contact MedImpact's Customer Service at (800) 788-2949.

**\*\*\* ONLY COMPLETED FORMS CAN BE PROCESSED \*\*\***

**Member/Provider Information:**

<b>Member's Name:</b>	<b>Prescriber Name:</b>
<b>Member's Network Health ID #:</b>	<b>Prescriber Specialty:</b>
<b>Member's DOB (mm-dd-yy):</b>	<b>DEA # (Required):</b> _____ <b>NPI #:</b> _____
<b>Pharmacy used by Member:</b>	<b>Prescriber Telephone Number/ Contact Name:</b>
<b>Pharmacy (Area Code) Telephone Number:</b>	<b>Prescriber (Area Code) Fax Number:</b>

<b>Date Requested:</b>	
<b>Requested Medication(s)</b>	
<i>Note: Pegasys (peginterferon alfa 2a) is Network Health's preferred pegylated interferon.</i>	
<b>Please check all that apply:</b>	
<input type="checkbox"/> Pegasys 180mcg (peginterferon alfa 2a):180mcg subcutaneously once a week. Quantity: _____ per month	
<input type="checkbox"/> PegIntron (peginterferon alfa 2b)	
<input type="checkbox"/> 50mcg: 1.5mcg/kg subcutaneously once a week.	Quantity: _____ per month
<input type="checkbox"/> 80mcg: 1.5mcg/kg subcutaneously once a week.	Quantity: _____ per month
<input type="checkbox"/> 120mcg: 1.5mcg/kg subcutaneously once a week.	Quantity: _____ per month
<input type="checkbox"/> 150mcg: 1.5mcg/kg subcutaneously once a week.	Quantity: _____ per month
<input type="checkbox"/> Infergen (interferon alfacon-1)	
<input type="checkbox"/> 9mcg subcutaneously three times a week.	Quantity: _____ per month
<input type="checkbox"/> 15mcg subcutaneously three times a week.	Quantity: _____ per month
<input type="checkbox"/> Ribavirin ( <b>Generic</b> )	
<input type="checkbox"/> 200mg capsules: Take ___ capsule(s) po qam and ___ capsule(s) po qpm.	Quantity: _____ per month
<input type="checkbox"/> 200mg tablets: Take ___ tablet(s) po qam and ___ tablet(s) po qpm.	Quantity: _____ per month
<input type="checkbox"/> Rebetol ( <b>Brand</b> )	
<input type="checkbox"/> 200mg capsules: Take ___ capsule(s) po qam and ___ capsule(s) po qpm.	Quantity: _____ per month
<input type="checkbox"/> 40mg/ml solution: Take ___ ml's po qam and ___ ml's po qpm	Quantity: _____ per month
<input type="checkbox"/> Copegus ( <b>Brand</b> )	
<input type="checkbox"/> 200mg tablets: Take ___ tablet(s) po qam and ___ tablet(s) po qpm.	Quantity: _____ per month
<input type="checkbox"/> Other: _____ Directions: _____	Quantity: _____ per month

# Network Health Prior Authorization Request for Hepatitis C Medications

## Documentation of Medical Necessity

**Please complete all that apply:**

- Diagnosis:  070.54 Hepatitis C (chronic)  Other: \_\_\_\_\_
- Does the patient have HIV co-infection?  Yes  No
- Has the patient been evaluated by a Gastroenterologist or Infectious Disease Specialist?  Yes  No  
If yes, When: \_\_\_\_\_
- Has the patient been previously treated for Hepatitis C and failed treatment  Yes  No  
If yes, When: \_\_\_\_\_ What treatment: \_\_\_\_\_
- HCV Genotype:  1a  1b  2  3  4  5  6
- HCV RNA (Baseline): \_\_\_\_\_ IU/ml Date of lab: \_\_\_\_\_
- HCV RNA (after 12 weeks of treatment if applicable): \_\_\_\_\_ IU/ml Date of lab: \_\_\_\_\_
- HCV RNA (after 24 weeks of treatment if applicable): \_\_\_\_\_ IU/ml Date of lab: \_\_\_\_\_
- Liver biopsy/Fibroscan (required for genotype 1 & 4)  Yes  No  
  
If yes, When: \_\_\_\_\_ Results: \_\_\_\_\_  
  
If no, Why: \_\_\_\_\_  
\_\_\_\_\_

## Documentation for the request of medications not included on the Network Health Preferred Drug List

PegIntron (peginterferon alfa 2b) - Please provide clinical justification as to why Pegasys cannot be used: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Rebetol / Copegus - Please provide clinical justification as to why generic ribavirin cannot be used: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Request for expedited review (72 hours):** By checking this box, I certify that applying the standard review time frame may seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

**SIGNATURE**

**I CERTIFY THAT THE INFORMATION PROVIDED IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE, AND I UNDERSTAND THAT ANY FALSIFICATION, OMISSION, OR CONCEALMENT OF MATERIAL FACT MAY SUBJECT ME TO CIVIL OR CRIMINAL LIABILITY.**

\_\_\_\_\_  
 Prescriber's signature (STAMP NOT ACCEPTED)

\_\_\_\_\_  
 Date

DO NOT WRITE IN SHADED AREAS FOR INTERNAL USE ONLY
Contacted:
Provider:
Pharmacy:
Patient:

DO NOT WRITE IN SHADED AREAS FOR INTERNAL USE ONLY
Approved:
Denied:
Returned:
PA #