

**PEGINTERFERON (HEPATITIS C)
PRIOR AUTHORIZATION
Physician Fax Form**



ONLY the prescriber may complete this form.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information, please visit the PrimeWest Health System web site at www.primewest.org.

Today's Date: _____

PATIENT INFORMATION

Patient Name (First):	Last:	M:	Patient's telephone #:	DOB (mm/dd/yy):
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INSURANCE INFORMATION

Member's Insurance ID Number:	Member's Insurance Group Number:
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PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:		Clinic Address:	
City, State, Zip:		Phone #:	Secure Fax #:

PRIOR AUTHORIZATION INFORMATION

Patient's Diagnosis:
Medication Requested:
<p>1. Is the patient currently treated with the requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was treatment with the requested medication started? _____</p> <p>2. If the diagnosis is hepatitis C or hepatitis B, has the diagnosis been confirmed by lab testing for the detection of serologic markers for the infection? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. If the diagnosis is hepatitis C, has peginterferon been prescribed as chronic maintenance therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Please list all reasons for selecting the requested peginterferon over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to previous peginterferon products.) _____</p> <p>_____</p> <p>_____</p>

Please fax or mail this form to:
PrimeWest Health System
Clinical Review Department
1020 Discovery Road, No. 100
Eagan, Minnesota 55121

TOLL FREE

Fax: 877.480.8130 **Phone:** 800.711.9866

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