

**2010 MEDICARE PART D
PEGINTERFERON (HEPATITIS C)
PHYSICIAN FAX FORM**



ONLY the prescriber may complete this form. This form is for Medicare Part D requests.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information, please visit www.myrxassistant.com and search for the appropriate health plan formulary.

Today's Date: _____

PATIENT, INSURANCE and PHYSICIAN/CLINIC INFORMATION

Patient Name (First):		Last:		M:	DOB (mm/dd/yy):
Insurance ID Number:			Patient Telephone Number:		
Prescribing Physician's Name:	Physician NPI#:		Specialty:	Clinic Contact Person's Name:	
Clinic Name:			Clinic Address:		
City, State, Zip:		Clinic Phone #:	Clinic Secure Fax #:		
Is the patient a long term care facility resident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the LTC facility contact's name, telephone and fax numbers					
LTC Contact Name:		LTC Phone #:	LTC Secure Fax #:		

DIAGNOSIS: _____	Date of Diagnosis: _____
(ICD-9 code plus description)	
MEDICATION REQUESTED:	Strength:
Dosing Schedule:	Expected duration of treatment:
<p>1. 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>2. Is the patient currently being 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>3. Has the patient completed in the past a treatment course with interferon or peginterferon?.. <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list dates (if known) _____</p> <p>4. Please list any other medications the patient will use in combination with the requested medication for treatment of this diagnosis. _____ _____</p> <p>5. Please include any additional information that should be considered for review of this request _____ _____ _____</p>	

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
1305 Corporate Center Drive
Eagan, Minnesota 55121

TOLL FREE

Fax: 800.693.6703 **Phone:** 800.693.6651

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