

**Physician's Prior Authorization Questionnaire
Pegasys® and Copegus®**

Patient:

ID#:

DOB:

Patient Address:

Pegasys® and Copegus® are covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

Is this an initial request for approval? Yes No

If Yes, answer questions 1 thru 3 only and submit this form. *An Early Viral Response (EVR) at week 12 will be necessary to determine if therapy will be continued beyond 16 weeks after initial approval.*

Is this a request for continued approval? Yes **List Genotype:** _____

If Yes, answer questions 4 thru 6 only and submit this form.

1. What is the diagnosis (with genotype) of the patient? _____

Diagnosed by: ELISA HCV RNA RIBA

2. Has this patient been treated for HCV prior to this request? Yes No

If Yes, please describe the previous treatment and duration: _____

3. What is the patient's weight in kilograms? _____

4. How many weeks has the patient been on therapy? _____

5. Has the patient shown an Early Viral Response (EVR)? Yes No

6. How many logs has the patient's viral load decreased since initiation of treatment? _____

Pegasys® and Copegus® will be shipped to the patient from our Specialty Pharmacy.

Physician's Signature

Date

Please **Print** Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx