

**Physician's Prior Authorization  
Questionnaire for Continuation of Infergen®**

PATIENT'S NAME: \_\_\_\_\_ ID#: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Please complete the questions below to assist us in making a determination of this patient's eligibility for coverage for this therapy.

1. What is the diagnosis (with genotype) of the patient? \_\_\_\_\_
2. How many weeks has the patient been on therapy? \_\_\_\_\_
3. Has the patient shown an Early Viral Reponse (EVR)? \_\_\_\_ Yes \_\_\_\_ No
4. How many logs has the patient's viral load decreased since initiation of treatment? \_\_\_\_\_
5. Please **print** the prescriber's specialty: \_\_\_\_\_

*Quantity Limits limit the dose to three times a week (TIW)*

*Arkansas Blue Cross Blue Shield Nurse Case Managers are available to monitor and provide support to your patients during their Course of Therapy*

_____ Physician's Signature	_____ Date
_____ Please <b>Print</b> Name	_____ Fax Number
_____ Please <b>Print</b> Physician's Specialty	_____ Phone Number

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

Sincerely,  
Pharmacy Programs

Forms are also available online at <http://usableadmin.abcbs.net/providers/PharmacyForms.aspx>