

Physician's Prior Authorization Questionnaire for Infergen®

PATIENT: _____ **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? _____
Diagnosed by: ___ELISA ___HCV RNA ___RIBA
Is there RNA or antibodies present? ___Yes ___No
2. Has this patient been treated for HCV prior to this request? ___Yes ___No
If yes, please describe the previous treatment and duration: _____

3. Is this patient considered to have not responded or relapsed? ___Yes ___No
If yes, which? _____
4. What is the patient's current viral level (in millions)? _____
5. Has the member had a biopsy of the liver? ___Yes ___No
If yes, does this patient have significant liver fibrosis or cirrhosis? ___Yes ___No
6. 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*

**PLEASE NOTE: An Early Viral Response (EVR) at week 12 will be necessary to determine if therapy will
be continued beyond 16 weeks after initial approval.**

_____ Physician's Signature	_____ Date
_____ Please Print Name	_____ Fax Number
_____ Please Print 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>