

**Physician's Prior Authorization Questionnaire for
Interferon Alfa-2b (Intron)**

PATIENT: _____ **ID#:** _____ **DOB:** _____

Patient Address: _____

1. Interferon 2-b (Intron) is being prescribed for this patient for the following reason(s):

- _____ Patient with chronic Hepatitis C with genotype 1 Infection
- _____ Patient with chronic Hepatitis C with genotype 2 and/or 3 Infection
- _____ Patient with chronic Hepatitis B with compensated liver disease who has Hepatitis B virus replication as indicated by a positive Hepatitis B antigen
- _____ Patient with AIDS-related Kaposi's Sarcoma who do not have severe immune dysfunction
- _____ Refractory or recurrent external Condyloma Acuminatum
- _____ Patient with Polycythemia Vera (not first line therapy)
- _____ Hairy Cell Leukemia in splenectomized or nonsplenectomized patients
- _____ Non-Hodgkin's Lymphoma
- _____ Malignant Melanoma
- _____ Multiple Myeloma
- _____ Mycosis Fungides
- _____ Carcinoid Tumors
- _____ Epithelial Ovarian Cancer
- _____ Basal Cell Carcinoma
- _____ Bladder Carcinoma
- _____ Renal Carcinoma
- _____ Chronic Myelocytic Leukemia
- _____ **OTHER, please list complete medical diagnosis:** _____

2. Will this medication be provided/administered/billed in your office? Yes No
3. Will patient purchase at a participating pharmacy and self-administer/use Home Health? Yes No
4. How long do you anticipate this patient being prescribed this medication? _____

_____ 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>