

Physician's Prior Authorization Questionnaire  
Interferon Alfa-2A (Roferon)

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

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

Interferon Alfa-2A (Roferon) is covered under certain medical conditions. Please furnish the information below to assist us in making a determination of this patient's eligibility by completing the following:

1. Intereron Alfa-2A (Roferon) is being prescribed for the medical diagnosis:

- \_\_\_\_\_ Carcinoma of the bladder, metastatic
- \_\_\_\_\_ Glioblastoma of the brain
- \_\_\_\_\_ Carcinoid syndrome (secondary to malignant carcinoid tumor)
- \_\_\_\_\_ Cancer of the cervix, metastatic
- \_\_\_\_\_ Chronic lymphocytic leukemia
- \_\_\_\_\_ Chronic myelocytic leukemia
- \_\_\_\_\_ Cutaneous T cell lymphoma
- \_\_\_\_\_ Cancer of the head and neck, metastatic
- \_\_\_\_\_ AIDS-related Kaposi's sarcoma in patients who have not previously had opportunistic infection (excluding Candida mucositis)
- \_\_\_\_\_ Hairy cell leukemia
- \_\_\_\_\_ Chronic myelogenous leukemia
- \_\_\_\_\_ Advanced colorectal carcinoma
- \_\_\_\_\_ Malignant melanoma, metastatic

Interferon 2-A (Roferon) con't

PATIENT: \_\_\_\_\_

ID#: \_\_\_\_\_

- \_\_\_\_\_ Renal cell carcinoma, metastatic
- \_\_\_\_\_ Multiple myeloma
- \_\_\_\_\_ Non-Hodgkin's lymphomas
- \_\_\_\_\_ Osteosarcoma, metastatic
- \_\_\_\_\_ Cancer of the pancreas, islets of Langerhans, metastatic
- \_\_\_\_\_ Other, specify \_\_\_\_\_

2. Will this medication be provided/administered/billed in your office \_\_\_\_\_

**OR**

Will patients purchase at a participating pharmacy and self-administer/use Home Health?

\_\_\_\_\_

3. How long do you anticipate this therapy to last? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
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>**