

Physician Request Form for Self Injectable Peg-Intron/Ribavirin, Pegasys, or Non Pegylated Interferons for Hepatitis C treatment

Fax to AmeriHealth Mercy Pharmacy Services at **888-981-5202**, or to speak to a representative call **866-610-2774**. Form must be completed for processing.



Patient Name: \_\_\_\_\_ Plan ID#: \_\_\_\_\_  
 Address: \_\_\_\_\_ Apt # or Suite #: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Birth date: \_\_\_\_\_

Physician Name: \_\_\_\_\_ License #: \_\_\_\_\_  
 Address: \_\_\_\_\_ Apt # or Suite #: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Deliver to:  Physician's Office  Patient's Home  Patient filling at local Pharmacy (Name) \_\_\_\_\_

Please check if the request is for a treatment-naïve patient or a continuation of therapy.

Start and End date of therapy: \_\_\_\_\_ to \_\_\_\_\_ Weight: \_\_\_\_\_ lbs or \_\_\_\_\_ kg

Treatment History:  Naïve to Therapy  Relapsed on Previous Peg Interferon/RBV Tx  Partial Responder\*  Null Responder\*\*  
 \*( > 2 log drop by week 12 on previous peginterferon and RBV therapy w/out achieving an undetectable level); \*\*(<2 log drop after 12 weeks of peginterferon and RBV therapy)

Continuation of therapy - Date started: \_\_\_\_\_

Does the member have cirrhosis?  YES  NO Is the member Co-Infected HIV/AIDS?  YES  NO

<p><b>Treatment-Naïve Patients (New Treatment starts) or Pre-Treatment Labs:</b></p> <p><input type="checkbox"/> Genotype 1 <input type="checkbox"/> Genotype 2 <input type="checkbox"/> Genotype 3 <input type="checkbox"/> Genotype Other: _____</p> <p>HCV Viral Load: IU/ml _____ or Copies/ml _____ Lab Date: _____</p> <p>Alanine Aminotransferase (ALT): _____ Normal range _____ Lab Date: _____</p> <p>Aspartate Aminotransferase (AST): _____ Normal range _____ Lab Date: _____</p> <p>For HIV Co-infected Members - CD4 Count _____ Lab Date: _____</p> <p>For HIV Co-infected Members - RNA Viral Load _____ Lab Date: _____</p> <p>Liver Biopsy Result or attach copy with request: _____</p>	<p><b>Continuation of Therapy</b></p> <p><b>FOUR (4) weeks after starting therapy:</b>                  HCV Viral Load: IU/ml _____ or Copies/ml _____                  Lab Date: _____ DETECTABLE <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><b>EIGHT (8) weeks after starting therapy:</b>                  HCV Viral Load: IU/ml _____ or Copies/ml _____                  Lab Date: _____ DETECTABLE <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><b>TWELVE (12) weeks after starting therapy:</b>                  HCV Viral Load: IU/ml _____ or Copies/ml _____                  Lab Date: _____ DETECTABLE <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><b>TWENTY FOUR (24) weeks after starting therapy:</b>                  HCV Viral Load: IU/ml _____ or Copies/ml _____                  Lab Date: _____ DETECTABLE <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p><b>Repeat Liver Function Labs:</b></p> <p>ALT: _____ Normal range _____ Lab Date: _____</p> <p>AST: _____ Normal range _____ Lab Date: _____</p>	<p><b>Repeat Liver Function Labs:</b></p> <p>ALT: _____ Normal range _____ Lab Date: _____</p> <p>AST: _____ Normal range _____ Lab Date: _____</p>

**Rx (please check the appropriate boxes and complete accordingly)**

<p><b>PEGASYS</b></p> <p><input type="checkbox"/> 180 mcg weekly</p> <p><input type="checkbox"/> Other dose and sig: _____</p>	<p><b>RIBAVIRIN 200 mg</b></p> <p><input type="checkbox"/> 400 mg BID (genotype 2&amp;3)</p> <p><input type="checkbox"/> 400 mg QAM and 600 mg QPM (genotype 1 or 4 &amp; &lt;75kg)</p> <p><input type="checkbox"/> 600 mg BID (genotype 1 or 4 &amp; ≥75kg)</p>
<p><b>PEG-INTRON</b></p> <p><input type="checkbox"/> Dose and sig: _____</p>	<p><b>RIBAVIRIN 200 mg</b></p> <p><input type="checkbox"/> Sig: _____</p>
<p><b>VICTRELIS</b></p> <p><input type="checkbox"/> 800 mg TID</p>	<p><b>INCIVEK</b></p> <p><input type="checkbox"/> 750 mg TID</p>

If requesting a medication other than Pegasys®, please provide documentation of a medical reason for why the patient is unable to take Pegasys® to treat their medical condition (attach any necessary documentation):

