

### PREAUTHORIZATION FORM

Pegasys™ (preferred) and Peg-Intron™ (non-preferred)  
 Victrelis™ (boceprevir) and Incivek™ (telaprevir)

**Therapeutic use:** Treatment of chronic Hepatitis C

**Authorization Period:**

- **Pegasys and Peg-Intron:** Genotype 2 and 3 will be approved for a total of 24 weeks, Genotype 1,4,5, & 6 will initially be approved for 24 weeks, extension will depend on virologic response.
- **Incivek:** treatment for a total of 12 weeks
- **Victrelis:** treatment initially approved for 24 weeks, extension will depend on virologic response.
- **Infergen is not covered**

Patient's name \_\_\_\_\_

Patient's ID#  DOB  /  /

ICD-9

Physician's name \_\_\_\_\_

Physician's Ph# (  )  -  Fax#  -

Physician's signature \_\_\_\_\_ Date signed  /  /

Supervising Physician's name \_\_\_\_\_ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" or answer the following questions:

1.	Is the prescribing physician a gastroenterologist or an infectious disease physician (or has a GI specialist been consulted)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Which pegylated interferon-alfa product is being requested? <input type="checkbox"/> Pegasys <input type="checkbox"/> Peg-Intron Note: Pegasys is preferred, a letter of medical necessity is required when requesting Peg-Intron		
3.	Is the patient diagnosed with chronic <b>hepatitis C</b> virus (HCV)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	What is the HCV genotype? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6		
5.	For genotype 1, is a protease inhibitor being requested? If yes, which product? <input type="checkbox"/> Victrelis <input type="checkbox"/> Incivek	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.	Has the patient been treated previously with pegylated interferon-alfa? If yes, please check one: <input type="checkbox"/> Partial responder <input type="checkbox"/> Relapser <input type="checkbox"/> Null responder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	Has the patient been treated previously with a protease inhibitor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	Has the patient had a liver biopsy showing bridging fibrosis or cirrhosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	What is the HCV RNA viral load at baseline? _____ Date: _____ What is the HCV RNA viral load at T4W? _____ Date: _____ What is the HCV RNA viral load at T8W? _____ Date: _____ What is the HCV RNA viral load at T12W? _____ Date: _____ What is the HCV RNA viral load at T24W? _____ Date: _____		

Alpha interferons may cause or aggravate fatal or life-threatening neuropsychiatric, autoimmune, ischemic, and infectious disorders. Therapy should be withdrawn in patients with persistently severe or worsening signs or symptoms of these conditions.

**This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.**