



Date _____

Client _____

PRIOR AUTHORIZATION CRITERIA- PEGASYS®

<i>M.D. Last Name:</i> _____	<i>M.D. First Name:</i> _____
<i>Physician Phone:</i> _____	<i>Physician Fax:</i> _____
<i>Patient</i> _____	<i>ID#</i> _____ <i>DOB</i> _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

1. Please check if any of the following applies:
- Patient has decompensated liver disease
 - Patient is an infant or neonate
 - Patient has hypersensitivity to Pegasys or any component of the product**
 - Patient is pregnant (or male whose partner is pregnant and <2 methods of contraception are being used)**
 - Patient has autoimmune hepatitis
 - Patient has not maintained sobriety for the last 6 months
 - Patient has a history of hemoglobinopathies
- **These are contraindications for combination with oral ribavirin only.**

- | | | |
|---|-----|----|
| 2. Is member now starting therapy (if this is a continuation, please SKIP to #7) | Yes | No |
| 3. Patient is diagnosed with Chronic Hepatitis C, not previously treated with interferon-alpha therapy? | Yes | No |
| 4. Patient is at least 18 years of age and has compensated liver disease? | Yes | No |

5. List the patient's weight in Kg (if PEGASYS will be used with Ribavirin): _____

7. Therapy Start Date: _____

8. First PCR Test Date: _____ 8a. Viral Load (viral copies/mL): _____

9. **For renewals:** Last PCR Test Date: _____ 9a. Viral Load (viral copies/mL): _____

10. List the Genotype: _____

- | | | |
|--|-----|----|
| 11. PEGASYS will be used for monotherapy | Yes | No |
| 12. PEGASYS will be used in combination with ribavirin | Yes | No |

If patient meets criteria, initial approval will be for 3 months subject to future HCV RNA virological results. Viral load should be measured at 0, 12 and 24 weeks and patient compliance verified to determine patient response. Approval for responders will be granted for an additional 3-6 months based on genotype and viral load results.

Total length of therapy: Genotypes 2/3 =6 months (24wks); Genotype 1/4/6=12 months (48 wks)

Physician Signature or name of person providing answers _____

Physician Comments _____

Send or Fax completed form to:
877-329-7279

RESTAT
P.O. BOX 758
WEST BEND, WI 53095

QUESTIONS PLEASE CALL:
877-526-9906