Please Note: Medical Necessity Prior Authorization may be overrided for both formulary coverage and benefit design restrictions. They are issued at the full discretion of the benefit manager.

PRIOR AUTHORIZATION BYPASS
Intron® A (interferon alpha 2b)

Bypass the Prior Authorizaton by Modifying the following Prescription Forms to the Patient's Needs

Name ______________________

Address ______________________

℞

Refer for Hepatitis Protocol

MD ______________________

Signature ______________________

Name ______________________

Address ______________________

℞ COMPLETE PRIOR AUTHORIZATION FORMS

as directed by physician

Dx: HEPATITIS B

ICD 10: B 19.10

MD ______________________

Signature ______________________

SAMPLE

Prescriber Information

Last Name:	First Name
DEA/NPI:	Specialty:
Phone ___ - ___ - ____	Fax ___ - ___ - ____

Member Information

Last Name:	First Name
Member ID Number	DOB: __ - __ - ____

Medication Information:

Drug Name and Strength:	Quantity and Dosing:
Diagnosis:	Duration:

When advised below, please include all requested fax documentation (lab results, etc.) when submitting this Prior Authorization fax form; not submitting requested documentation could delay the clinical review process.

Intron A Prior Authorization Form

You must answer ALL of the following questions		
1. Is the patient 18 years of age or older?	Y	N
2. What is the patient's diagnosis? **(Please circle)** • Hairy cell leukemia • Malignant melanoma • Follicular non-Hodgkin's lymphoma • Condylomata acuminate • AIDS-related Kaposi's sarcoma • Chronic hepatitis C *(must provide baseline labs)* • Renal carcinoma • Relapsed/refractory advanced cutaneous T-cell lymphoma *(submitted chart notes required)* • Other ________________		
3. Is the patient free of disease but at high risk of systemic recurrence within 56 days of surgery?	Y	N
4. Is the prescribed medication being used in conjunction with antracycline-containing chemotherapy?	Y	N
5. Is the prescribed medication being used intralesionally?	Y	N
6. Does the condition involve external surfaces of the genital and perianal area?	Y	N
7. Does the patient have compensated liver disease?	Y	N
8. Is the medication being prescribed by a gastroenterologist, infectious disease physician, hepatologist, or a transplant physician?	Y	N

Question	Y	N
9. Does the patient have a history of hepatic encephalopathy, variceal bleeding, ascites, or other clinical signs of decompensation?	Y	N
10. Is the patient's bilirubin level less than or equal to 2 mg/dL? *Must provide lab documentation.*	Y	N
11. Are albumin levels stable and within normal limits? *Must provide lab documentation.*	Y	N
12. Is the patient's prothrombin time less than 3 seconds prolonged? *Must provide lab documentation.*	Y	N
13. Is the patient white blood count (WBC) greater than or equal to 3,000/mm³? *Must provide lab documentation.*	Y	N
14. Is the patient's platelet count greater than or equal to 70,000/mm³? *Must provide lab documentation.*	Y	N
15. Does the patient have a diagnosis of hepatitis B?	Y	N
16. Is the patient 1 year of age or older?	Y	N
17. Has the patient been serum HBsAg positive for at least 6 months with evidence of HBV replication (serum HBeAg positive) and elevated serum ALT? *Must provide lab documentation.*	Y	N
18. Is the patient's bilirubin level normal? *Must provide lab documentation.*	Y	N
19. Is the patient's prothrombin time less than 3 seconds prolonged for adults or less than or equal to 2 seconds prolonged for children? *Must provide lab documentation.*	Y	N
20. Is the patient's white blood count (WBC) greater than or equal to 4,000/mm³? *Must provide lab documentation.*	Y	N
21. Is the patient's platelet count greater than or equal to 100,000/mm³ for adults or greater than or equal to 150,000/mm³ for pediatric patients? *Must provide lab documentation.*	Y	N
22. Is the patient using the prescribed medication as monotherapy or in combination with bevacizumab as 1st line therapy for relapsed or medically unresectable stage IV disease with predominant clear cell histology?	Y	N
23. Is this a request for initial or renewal of therapy?	Y	N
24. Has the patient been tolerant of therapy and have they had a positive continued response?	Y	N

Please note, not all drugs/diagnoses are covered on all plans.

Comments: ____

Information given on this form is accurate as of this date.

Prior Authorization forms are located on the Cover Page. Print a new form for each request as forms are updated periodically.

____ ________________________

Prescriber or Authorized Signature **Date**

____

Authorized Medical Staff – Name/Title

Attention Healthcare Provider: If you would like to discuss this request with a medical professional, please contact the Prior Authorization Department whose numbers appear on the Cover Page.

I understand that USDoctor's use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

Contact Information:

Telephone: (855)251.9116
Fax: (248)593.9575

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PRIOR AUTHORIZATION FORM: COVER PAGE

MEMBER INFORMATION			
First Name		**Last Name**	
Plan			
Member ID		**Date of Birth**	
DRUG INFORMATION			
Drug Name			
Quantity		**ICD-10**	
Directions		**Duration of Therapy**	
Diagnosis			
PLEASE LIST ALTERNATIVE THERAPIES THAT HAVE BEEN ATTEMPTED AND ANY OTHER PERTINENT INFORMATION RELATED TO DRUG AND/OR DISEASE STATE. IF NOT PRESENT, WITHIN NORMAL LIMITS WILL BE USED FOR THE REVIEW.			
Medication/Failure Reason:			

IgE:_______________

ESR:________________ **CRP:**________________ **# Joints:**________________ **%BSA:**_______________

Height:________________ **Weight:**________________ **BMI:**________________

HA1C:________________ **Hemoglobin:**________________ **Hematocrit:**________________ **T-Score:**______________

Dialysis:______________ **Long Term Care Facility:**______________ **Self Injecting:**______________

Stimulation test:__________/__________ **Growth velocity:**___________ **#Chemotherapy cycles/month:**__________

Mini-Mental Status Test:_____________ **Baseline Free testosterone/Total testosterone:**__________/_________

HCV RNA viral load:_______________ **Viral Genotype:**________________ **ALT:**________________

PHYSICIAN INFORMATION			
Physician Signature		**Date**	
Physician Name		**NPI #**	
Phone Number		**Fax Number**	
Action Needed	Only mark Urgent when standard review time would seriously harm the member's life or health or ability to regain maximum function ☐ Urgent ☐ For Review	**Pharmacy Fax**	

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