



Date of Request: \_\_\_\_\_

### Sterling Retiree Rx Prior Authorization Form

#### INFERGEN (interferon alfacon-1)

**Coverage Criteria**

Diagnosis of chronic hepatitis C

**Required Medical Information**

Presence of anti-HCV serum antibodies or detectable levels of HCV RNA

**Exclusion Criteria**

Non FDA-approved use

#### Member Information

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

#### Physician Information

Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			

#### Requested Drug

INFERGEN	Reason for Request				
Condition/Diagnosis Related					

#### Clinical Drug/Lab History Pertinent to Request

Labs: Baseline/Ongoing		Strength/Dosage			
Formulary Alternative(s) Attempted?		Yes:		No:	
Please List Alternative Formulary Drugs					

Comments					
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Physicians Signature: \_\_\_\_\_ Fax Form to 1-877-847-9904