



Date of Request: _____

Sterling Retiree Rx Prior Authorization Form

PEG-INTRON (Interferon alfa-2b)

Coverage Criteria

Patient must have Chronic Hepatitis C.

Renewals require clinical evidence of a 2-log decrease in viral load.

Required Medical Information

Patient must have compensated liver disease with detectable levels of hepatitis C virus RNA in the serum

Exclusion Criteria

Non FDA approved treatment

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

PEG-INTRON	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