



Date of Request: _____

Sterling Retiree Rx Prior Authorization Form**PEGASYS (Interferon alfa-2a)****Coverage Criteria**

Patient must have Chronic Hepatitis B or Chronic Hepatitis C

Required Medical InformationFor chronic hepatitis B, patient must have a positive serum marker for HBV replication, persistently elevated aminotransferase levels greater than 2 times ULN **or** signs of chronic hepatitis B on liver biopsy **or** cirrhosis of the liver as evidenced by radiological or clinical data **or** extrahepatic complications.For chronic hepatitis C, patient must have compensated liver disease with detectable levels of HCV RNA in the serum. (For **renewal**, patient must have a 2-log decrease in viral load.)**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

PEGASYS	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

Physician Signature: _____ Fax Form to 1-877-847-9904