

**PEGINTERFERON (HEPATITIS C)  
 PREAUTHORIZATION REQUEST  
 PHYSICIAN FAX FORM**



**BlueCross BlueShield  
 of Illinois**

**ONLY the prescriber may complete and fax this form.**

**Incomplete forms will be returned for additional information.** The following documentation is required for preauthorization consideration. For formulary information and to download additional forms, please visit [www.bcbsil.com](http://www.bcbsil.com)

**Today's Date:** \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip	Patient Telephone:	

**INSURANCE INFORMATION**

BCBS ID Number:	Group Number:
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**PHYSICIAN/CLINIC INFORMATION**

Prescriber Name:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

Patient's Diagnosis - ICD-9 code plus description:	Date of Diagnosis:
Medication Requested:	Strength:
Dosing Schedule:	Expected duration of treatment:
<p>1. If the diagnosis is hepatitis C or hepatitis B, has the diagnosis been confirmed by lab testing for the detection of serologic markers for the infection? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Is the patient <b>currently being treated</b> with the requested medication? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No          If yes, when was treatment with the requested medication started? _____</p> <p>3. Has the patient <b>completed in the past</b> a treatment course with interferon or peginterferon? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No          If yes, list dates (if known) _____</p> <p>4. If the diagnosis is hepatitis C, has the HCV RNA level been checked after 6 months (24 weeks) of therapy to confirm therapeutic response? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No          If yes, is the HCV RNA level negative or decreased by two log<sub>10</sub> units? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. If the diagnosis is hepatitis C, has peginterferon been prescribed as chronic maintenance therapy? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Please list all reasons for selecting the requested <b>medication</b> over alternative peginterferon products (e.g. adverse reaction to other products) _____          _____</p> <p>7. Please include any additional information that should be considered for review of this request _____          _____          _____</p>	

**Please fax or mail this form to:**  
 Blue Cross and Blue Shield of Illinois  
 c/o Prime Therapeutics LLC, Clinical Review Department  
 1305 Corporate Center Drive  
 Eagan, Minnesota 55121

**TOLL FREE**

**Fax: 877.480.8130      Phone: 800.285.9426**

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