Physician Request Form for Self Injectable Pegasys/Ribavirin, Peg-Intron, or Non Pegylated Interferons for Hepatitis C treatment

KEYSTONE MERCY HEALTH PLAN
A Program of Keystone First and Mercy Health Plan

Fax to Keystone Mercy Pharmacy Services at 215-937-5018, or to speak to a representative call **800-588-6767**. *Form must be completed for processing.*

Patient Name: ______________________ Plan ID#: ______________

Address: ______________________ Apt # or Suite #: ______________

City: ______________ State: ________ Zip Code: ______________

Phone #: ______________ Birth date: ______________

Physician Name: ______________________ License #: ______________

Address: ______________________ Apt # or Suite #: ______________

City: ______________ State: ________ Zip Code: ______________

Contact Person: ______________ Phone #: ________ Fax #: ______________

Physician Signature: ______________________

Deliver to: ☐ Physician's Office ☐ Patient's Home ☐ Patient filling at local Pharmacy (Name) ______________

Please check if request is for Naïve Patient or Continuation of therapy.

☐ Naïve Patient or New treatment start Start and End date of therapy: ________ to ________ Weight: ________ lbs or ________kg

- Does the patient have a history of receiving treatment? ☐ YES ☐ NO
- If yes, please indicate medication including dates, and dosage: ______________
- If yes, please indicate accordingly: ☐ NON-RESPONDER TO PREVIOUS TREATMENT ☐ RELAPSER AFTER PREVIOUS TREATMENT

☐ Continuation Therapy - Date started: ______________

Is Member Co-infected with HIV? ☐ YES ☐ NO

For treatment-Naïve patients or New treatment starts, please submit a current (within 1 month) HCV viral titer, and AST/ALT lab results with the form or indicate below on the form. If AST/ALT are within normal limits, a liver biopsy is required to document active disease.
For continuation of therapy (treatment beyond 12 weeks), repeat HCV viral load, AST, & ALT 12 weeks after the initiation of therapy and submit lab results or indicate on form **and** submit pre-treatment labs or indicate on form below for reauthorization before 16 weeks after starting therapy so reauthorization is done in a timely manner.

Naïve Patients (New Treatment starts) or Pre-Treatment Labs:	Continuation of Therapy (labs after 12 weeks of therapy):
Genotype: ________ Lab Date:________	
HCV Viral Load: IU/ml________ or Copies/ml________ Lab Date: ________	HCV Viral Load: IU/ml________ or Copies/ml________ Lab Date:________
Alanine Aminotransferase (ALT): ________ Normal range________ Lab Date:________	ALT: ________ Normal range________ Lab Date:________
Asparate Aminotransferase (AST): ________ Normal range ________ Lab Date:________	AST: ________ Normal range________ Lab Date:________
For HIV Co-infected Members - CD4 Count ________ Lab Date:________	
For HIV Co-infected Members - RNA Viral Load ________ Lab Date:________	
Liver Biopsy Result or attach copy with request: ______________	

Rx (please check the appropriate boxes and complete accordingly)

PEGASYS	RIBAVIRIN 200 mg
☐ 180 mcg weekly ☐ Other dose and sig: ______________	☐ 400 mg BID *(genotype 2&3)* ☐ 400 mg QAM and 600 mg QPM *(genotype 1 or 4 & <75kg)* ☐ 600 mg BID *(genotype 1 or 4 & ≥75kg)*

PEG-INTRON	RIBAVIRIN 200 mg
☐ Dose and sig: ______________	☐ Sig: ______________
NON-PEGYLATED INTERFERON PRODUCT *(please specify requested product):* ______________ ☐ Dose and sig: ______________	RIBAVIRIN 200 mg ☐ Sig: ______________

If requesting a medication other than Pegasys®, please provide documentation of a medical reason for why the patient is unable to take Pegasys® to treat their medical condition (attach any necessary documentation):

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