Hepatitis Prior Authorization & Fax Order Form

Please indicate the intention of this request:

☐ Prior authorization and Cigna Home Delivery pharmacy to fill ***Please deliver by:*** _____

☐ Prior authorization only (or call (800) 244-6224)

Order #:_____ **Referral Source Code:**___652_____ **Fax:**1.800.351.3616 **Phone:** 1.800.351.3606

PATIENT INFORMATION (Please Print)			**PHYSICIAN INFORMATION**		
PATIENT NAME:	DATE OF BIRTH :		NAME:		
HEALTH CARE ID #:	GENDER: ☐ M ☐ F		DEA #:	NPI:	TIN:
HOME PHONE:	ALT PHONE:		ADDRESS: (Street/Suite #) (City) (State) (Zip Code)		
ADDRESS: (Street) (City) (State) (Zip Code)					
ALLERGIES: If no allergies are specified, for new customers this indicates no known allergies and for existing customers this indicates no change from information previously provided to Cigna.			TELEPHONE:	FAX:	

SHIP MEDICATIONS TO: ☐ Patient's Home (Please provide all available patient phone numbers as they are REQUIRED for scheduling delivery.) ☐ Physician's Office

PRESCRIPTION INFORMATION

* **PEGASYS®** (Peginterferon Alfa-2a - S0145): ☐ **180 mcg/0.5 ml Prefilled Syringe** ☐ **180 mcg/0.5ml Proclick** ☐ Pharmacy asks patient for preference	**Directions:** DIRECTIONS: ☐ Inject 180 mcg SQ weekly ☐ Other (please specify):	**Refills:** QTY/REFILLS ☐ 1 month supply _____ refills ☐ Other: _____QTY _____ refills
* **PEGASYS®** (Peginterferon Alfa-2a - S0145): ☐ **180 mcg/1 ml Vial** **Note: Concentration of Syringe vs. Vial**		
*** PEGASYS®** (Peginterferon Alfa-2a – S0145): ☐ **135 mcg/0.5ml Proclick**	DIRECTIONS: ☐ Inject 135 mcg SQ weekly	
*** PEG-INTRON®** (Peginterferon Alfa-2b – S0146): ☐ 50 mcg/0.5 ml **Vial** ☐ 50 mcg/0.5 ml **Redipen** ☐ 80 mcg/0.5 ml **Vial** ☐ 80 mcg/0.5 ml **Redipen** ☐ 120 mcg/0.5 ml **Vial** ☐ 120 mcg/0.5 ml **Redipen** ☐ 150 mcg/0.5 ml **Vial** ☐ 150 mcg/0.5 ml **Redipen**	DIRECTIONS: ☐ Inject 0.4 ml SQ weekly ☐ Inject 0.5 ml SQ weekly ☐ Other (please specify):	
INFERGEN® (Interferon Alfacon-1 – J9212): ☐ **9 mcg/0.3 ml Vial** ☐ **15 mcg/0.5 ml Vial**	DIRECTIONS: ☐ Inject 9 mcg SQ 3 times per week ☐ Inject 15 mcg SQ 3 times per week ☐ Other (please specify):	
☐ **Rebetol®** 200 mg capsules ☐ **Copegus®** 200 mg tablets	DIRECTIONS: _____ QAM AND _____ QPM	QTY/REFILLS ☐ 1 month supply _____ refills ☐ Other: _____QTY _____ refills
*** INCIVEK** (Telaprevir) ☐ 375 mg tablets	DIRECTIONS: ☐ Take 750mg (2 tablets) by mouth 3 times a day with food containing 20gm of fat	QTY/REFILLS ☐ 1 month supply _____ refills ☐ Other: _____ QTY _____ refills
VICTRELIS (Boceprevir) ☐ 200 mg capsules	DIRECTIONS: ☐ Take 800mg (4 capsules) by mouth 3 times a day with food, start at day 29 (week 5).	

☐ **Lab reminder coordination and injection training**

SUPPLIES NEEDED *(if medication is to be administered in patient's home)*: If checked, please specify the size and type (if applicable):

☐ Syringes/Needles ☐ Swabs ☐ Sharps Container ☐ Other:

PHYSICIAN'S SIGNATURE: (Physician's signature indicates accuracy and completeness of prescription information)

In order for a brand name product to be dispensed, the prescriber must handwrite ***"Brand Necessary"*** or ***"Brand Medically Necessary"*** on the prescription

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PATIENT NAME:	HEALTH CARE ID #:	DATE OF BIRTH:

The following levels are needed for approval of the below corresponding treatments.

HCV RNA Levels

Week of Therapy	Incivek	Victrelis	Dual or Mono Therapy*	Date Taken
Pretreatment			iu/ml	
4	iu/ml	iu/ml		
8		iu/ml		
12	iu/ml	iu/ml	iu/ml	
24	iu/ml	iu/ml	iu/ml	
other	iu/ml	iu/ml	iu/ml	

*Dual or Mono Therapy is defined as Infergen, Pegasys, Peg-Intron, or Intron A therapy with or without ribavirin.

Clinical Information:

What is the patient's current weight? _____ ☐ lbs ☐ kg

Diagnosis related to use: ☐ Hepatitis C ☐ Hepatitis B ☐ Other (please specify):

Does the patient have decompensated liver disease ☐ Yes ☐ No

(e.g. *of decompensated liver disease include: Ascites, Hepatic Encephalopathy, bleeding esophagogastric varicie*)?

What is the patient's genotype? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ Other:

Does the patient have HIV/AIDS? ☐ Yes ☐ No

Does the patient have bridging fibrosis? ☐ Yes ☐ No

Does the patient have cirrhosis? ☐ Yes ☐ No

Does the patient have steatosis? ☐ Yes ☐ No

Has the patient previously taken Pegasys or Peg-Intron plus ribavirin? ☐ Yes ☐ No

If *yes*: Which one of the following describes previous therapy:

- ☐ completed therapy but relapsed
- ☐ partial response
- ☐ stopped treatment early (weeks completed _____)
- ☐ no response (did not have at least a 2 log drop in HCV after 12 weeks of prior treatment)

If *no*: Is the patient currently on therapy? ☐ Yes ☐ No

How many weeks has the patient completed? _____ weeks

Date started therapy? __/__/__

Infergen requests:

Did the patient have intolerance to treatment with Pegasys or Peg-Intron? ☐ Yes ☐ No

For Incivek or Victrelis requests:

Will this be used in combination with ribavirin? ☐ Yes ☐ No

Will this be used in combination with Pegasys or Peg-Intron? ☐ Yes ☐ No

Does the patient have a history of a liver or another solid organ transplant? ☐ Yes ☐ No

Has the patient failed Victrelis/Incivek or another HCV NS3/4A protease inhibitor? ☐ Yes ☐ No

Does the patient have a hepatitis B coinfection? ☐ Yes ☐ No

Additional pertinent information:

PHYSICIAN'S SIGNATURE: (Physician's signature indicates accuracy and completeness of prescription information)

Our drug list can be viewed online at http://www.cigna.com. Prior authorization requests may also be submitted by calling (800) 244-6224.

CIGNA Preferred Status:

- It is the decision of the prescribing physician in the exercise of his/her independent clinical judgment to determine which medication to prescribe. Coverage is not limited to the preferred drug.
- CIGNA HealthCare may receive payments from manufacturers whose medications are included on the Preferred Specialty (Injectable) Drug List. These payments may or may not be shared with the member's benefit plan dependent on the contractual arrangement between the plan and CIGNA.
- Depending upon plan design, market conditions, the extent to which manufacturers' payments are shared with the member's benefit plan, and other factors as of the date of service, the preferred medication may or may not represent the lowest cost medication within the therapeutic class for the member and/or the benefit plan.
- CIGNA HealthCare reserves the right to make changes to its Preferred Specialty (Injectable) Drug List without notice.