

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

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 the request is for a treatment-naïve patient or a continuation of therapy.

Start and End date of therapy: _____ to _____ Weight: _____ lbs or _____ kg

Treatment History: Naïve to Therapy Relapsed on Previous Peg Interferon/RBV Tx Partial Responder* Null Responder**

*(> 2 log drop by week 12 on previous peginterferon and RBV therapy w/out achieving an undetectable level); **(<2 log drop after 12 weeks of peginterferon and RBV therapy)

Continuation of therapy - Date started: _____

Does the member have cirrhosis? YES NO

Is Member Co-infected with HIV? YES NO

Treatment-Naïve Patients (New Treatment starts) or Pre-Treatment Labs:	Continuation of Therapy
<input type="checkbox"/> Genotype 1 <input type="checkbox"/> Genotype 2 <input type="checkbox"/> Genotype 3 <input type="checkbox"/> Genotype Other: _____ HCV Viral Load: IU/ml _____ or Copies/ml _____ Lab Date: _____ Alanine Aminotransferase (ALT): _____ Normal range _____ Lab Date: _____ Aspartate Aminotransferase (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: _____ _____	FOUR (4) weeks after starting therapy: HCV Viral Load: IU/ml _____ or Copies/ml _____ Lab Date: _____ DETECTABLE <input type="checkbox"/> YES <input type="checkbox"/> NO EIGHT (8) weeks after starting therapy: HCV Viral Load: IU/ml _____ or Copies/ml _____ Lab Date: _____ DETECTABLE <input type="checkbox"/> YES <input type="checkbox"/> NO TWELVE (12) weeks after starting therapy: HCV Viral Load: IU/ml _____ or Copies/ml _____ Lab Date: _____ DETECTABLE <input type="checkbox"/> YES <input type="checkbox"/> NO TWENTY FOUR (24) weeks after starting therapy: HCV Viral Load: IU/ml _____ or Copies/ml _____ Lab Date: _____ DETECTABLE <input type="checkbox"/> YES <input type="checkbox"/> NO
Repeat Liver Function Labs:	Repeat Liver Function Labs:
-ALT: _____ Normal range _____ Lab Date: _____ AST: _____ Normal range _____ Lab Date: _____	ALT: _____ Normal range _____ Lab Date: _____ AST: _____ Normal range _____ Lab Date: _____

Rx (please check the appropriate boxes and complete accordingly)

PEGASYS <input type="checkbox"/> 180 mcg weekly <input type="checkbox"/> Other dose and sig: _____	RIBAVIRIN 200 mg <input type="checkbox"/> 400 mg BID (<i>genotype 2&3</i>) <input type="checkbox"/> 400 mg OAM and 600 mg OPM (<i>genotype 1 or 4 & <75kg</i>) <input type="checkbox"/> 600 mg BID (<i>genotype 1 or 4 & ≥75kg</i>)
PEG-INTRON <input type="checkbox"/> Dose and sig: _____	RIBAVIRIN 200 mg <input type="checkbox"/> Sig: _____
VICTRELIS <input type="checkbox"/> 800 mg TID	INCIVEK <input type="checkbox"/> 750 mg TID

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):