

Pharmacy Pre-authorization Form: Hepatitis C

Date: _____ Physician Name: _____
Member Name: _____ Physician Specialty: _____
Member ID Number: _____ Physician Address: _____
Member DOB: _____ Physician Telephone: _____
Physician Fax/E-mail: _____

Medication(s) requested: _____

Dose/expected duration of treatment: _____

*****Important Note*****

ConnectiCare's preferred interferon for the treatment of Hepatitis C is Pegasys.

Is there a clinical reason why the above patient cannot use Pegasys? [] Yes [] No (Pegasys can be used)

If "Yes," please provide rationale and supporting clinical literature _____

For an initial approval please provide the following information:

1. Does member have documented diagnosis of Hepatitis C? [] Yes [] No

2. Has a baseline viral load count been completed? [] Yes [] No
(Please supply lab report.)

3. What is patient's Hepatitis C genotype? _____

ICD9/ICD10 Code(s): _____

ICD9/ICD10 codes are REQUIRED to process all requests.

4. Has patient been on prior interferon therapy? [] Yes [] No

If "Yes," please provide drug name(s), dates, and duration of therapy and outcome:

For continuation of therapy (genotype 1 or 4) please provide the following information:

1. Has the patient demonstrated EVR (minimum 2 log decrease in viral load during
first 12 weeks of treatment)? [] Yes [] No

If "Yes," please provide baseline and follow up viral load lab reports.

ConnectiCare Pharmacy Services: FAX — (860) 674-2851, or e-mail — pharmacy@connecticare.com
To speak to a Medical Director or Pharmacist regarding a pre-authorization decision, call 1-800-828-3407.

This is confidential information. If you receive this form in error, please notify Provider Services immediately at 1-800-828-3407.
The information in this document does not apply to ConnectiCare VIP Medicare plan members.