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|--|
| <input type="checkbox"/> Preferred drug rejected by physician.<br><input type="checkbox"/> Preferred drug accepted. New verbal order authorized. |
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**Health New England  
Medication Request Form (MRF)**

**Pegasys® (peginterferon alfa-2a), and PEG-Intron® (peginterferon alfa-2b)**

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|--|
| DO NOT WRITE IN BLOCKED AREAS<br>FOR INTERNAL USE ONLY |
| Contacted:   |
| Physician:   |
| Pharmacy:  |
| Patient:   |
|  |
|  |

**Prior Authorization**

|  |
|--|
| DO NOT WRITE IN BLOCKED AREAS<br>FOR INTERNAL USE ONLY |
| Approved:  |
| Quantity approved:                                     |
| PA from and thru date:                                 |
| PA #   |
| Denied:  |
| Returned:  |

**Instructions:**

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Pegasys® and Peg-Intron®. Please complete this form and fax to ICORE Healthcare at (866) 364-2673. If you have any questions regarding this process, please contact the ICORE Healthcare at (800) 775-5138.

**Medication Request Information (please complete each section of this form prior to transmittal):**

| Patient Information (all required)         | Physician Information (all required)   |
|--|--|
| <b>Patient Name:</b>                       | <b>Physician Name:</b>                 |
| <b>Patient Cell Phone #: (     )     -</b> | <b>Specialty:</b>                      |
| <b>Patient HNE ID#:</b>                    | <b>NPI #:</b>                          |
| <b>Patient Date of Birth:</b>              | <b>HNE Provider #:</b>                 |
| <b>Allergies:</b>                          | <b>DEA #:</b>                          |
| <b>Diagnosis:</b>                          | <b>Telephone #: (     )     -</b>      |
|  | <b>Fax # (required): (     )     -</b> |

**Drug Information**

|  |                              |                 |
|--|------------------------------|-----------------|
| <b>Preferred Drug:</b> <input type="checkbox"/> Pegasys  |                              |                 |
| <b>Requested Drug/Strength/Form:</b>   |                              |                 |
| <b>Dose, Directions, and length of treatment (please be specific):</b><br><small>HNE will approve 4 injections per 28 days for 24 or 48 weeks, depending on diagnosis.</small> | <b>Quantity (per month):</b> | <b>Refills:</b> |

|                             |              |
|-----------------------------|--------------|
| <b>Physician Signature:</b> | <b>Date:</b> |
|-----------------------------|--------------|

**Indication:**

Chronic Hepatitis C (new treatment, with ribavirin,)  
 Chronic Hepatitis C (new treatment, monotherapy)  
 Hepatitis B (HBeAg positive and HBeAg negative)  
 Continuation of therapy for Chronic Hepatitis C  
 Other (please describe): \_\_\_\_\_

**Documentation of Medical Necessity (check all that apply):**

Patient has not been treated with interferon in the past  
 Patient is over age 18  
 Patient is HIV positive  
 Genotype is \_\_\_\_\_  
 Viral load is \_\_\_\_\_  
 FOR RENEWAL ONLY: Viral load has decreased by 2 log since treatment was initiated.  
 Other pertinent history: \_\_\_\_\_