

- Preferred drug rejected by physician.
- Preferred drug accepted. New verbal order authorized.

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 FOR INTERNAL USE ONLY |
| Contacted: |
| Physician: |
| Pharmacy: |
| Patient: |
| |
| |

Prior Authorization

| |
|--|
| DO NOT WRITE IN BLOCKED AREAS 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) |
|--|--|
| Patient Name: | Physician Name: |
| | Specialty: |
| Patient Cell Phone #: () - | NPI #: |
| Patient HNE ID#: | HNE Provider #: |
| Patient Date of Birth: | DEA #: |
| Allergies: | Telephone #: () - |
| Diagnosis: | Fax # (required): () - |

Drug Information

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

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 has liver biopsy showing fibrosis
- 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: _____