

**Request Form for Hepatitis C treatment
(peg-interferon alfa-2b [PEG-Intron®], peg-interferon alfa-2a [Pegasys®])**

Physician Information

Name: _____
License: _____ Physician specialty: _____
Address: _____
Telephone: _____ Fax: _____

Patient Information

General Information

Name: _____ Member ID: _____
Date of birth: _____ Address: _____
Sex: M F Weight: _____

Medication requested:

Name: _____ Dose: _____
Name: _____ Dose: _____

Medical Information

Please answer the following questions:

3) Treatment phase

- 1) Patient has been diagnosed with hepatitis C
- Acute Hepatitis C (ICD9 070.51)
 - Chronic Hepatitis C (ICD9 070.54)
 - Hepatitis C with HIV coinfection (Pegasys®)

Genotype 1 and Genotype 4:

- Initial treatment will be authorized for **12 weeks**
- For **12 additional weeks** – Please provide results of a second viral load test (is recommended to be done in the same clinical laboratory were the first test was performed)
- For **24 additional weeks** – Please provide results of a third viral load test (is recommended to be done in the same clinical laboratory were the first test was performed)

- 2) Please provide with the **first** prescription the following results:
- Genotype test
 - Viral Load test

Genotype 2 and Genotype 3:

- Treatment will be authorized for **24 weeks only**

Please provide any medical information which may support approval: (optional)

Physician signature: _____

Date: _____