Prescriber Criteria Form

Pegasys 2025 PA Fax 556-A v2 010125.docx
Pegasys (peginterferon alfa-2a)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Pegasys (peginterferon alfa-2a).

Drug Name:
Pegasys (peginterferon alfa-2a)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of chronic hepatitis C virus (HCV) infection that has been confirmed by the presence of hepatitis C virus ribonucleic acid (HCV RNA) in the serum prior to starting treatment and the planned treatment regimen? [If no, then skip to question 6.]	Yes ◯	No ◯
2	Is the requested drug being prescribed as monotherapy or as dual therapy with ribavirin? [If no, then skip to question 4.]	Yes ◯	No ◯
3	Has the patient received a total 48 weeks of treatment? [No further questions.]	Yes ◯	No ◯
4	Is the requested drug being prescribed as part of a three-drug regimen that includes Sovaldi and ribavirin? [If no, then no further questions.]	Yes ◯	No ◯
5	Has the patient received a total 12 weeks of treatment? [No further questions.]	Yes ◯	No ◯
6	Does the patient have a diagnosis of chronic hepatitis B virus infection? [If yes, then no further questions.]	Yes ◯	No ◯
7	Does the patient have a diagnosis of any of the following: A) Myeloproliferative neoplasm (essential thrombocythemia, polycythemia vera, symptomatic lower risk myelofibrosis), B) Systemic mastocytosis, C) Adult T-cell leukemia/lymphoma, D) Mycosis fungoides/Sezary	Yes ◯	No ◯

	syndrome, E) Primary cutaneous CD30+ T-cell lymphoproliferative disorders, F) Hairy cell leukemia, G) Erdheim-Chester disease? [If yes, then no further questions.]		
8	Does the patient have a diagnosis of chronic myeloid leukemia? [If no, then no further questions.]	Yes ◯	No ◯
9	Is the requested drug being used as initial treatment during pregnancy?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____