

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

Pegasys & PegIntron

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO 855-828-4992 note the new fax number**

CRITERIA:

- Documented diagnosis of Hepatitis B

AND / OR

- Documented diagnosis of Hepatitis C

NOTES:

Pegasys and PegIntron are available to Non-Traditional Medicaid clients.

AUTHORIZATION:

Authorization will be given for one 48-week supply.

RE- AUTHORIZATION:

Coverage may be extended to 72 weeks in patients with a documented late viral response (defined as failure to clear the virus until weeks 12-24 of treatment). This means that if a patient's viral load is between 49 and 65,000,000 at any point between weeks 12 and 24, a total of 72 weeks' treatment may be authorized.

05/05/11

<http://health.utah.gov/medicaid/pharmacy>