

**PEGINTERFERON (HEPATITIS C)
PREAUTHORIZATION REQUEST
PHYSICIAN FAX FORM**



**BlueCross BlueShield
of Texas**

ONLY the prescribing physician may complete and fax this form.

Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information and to download additional forms, please visit www.bcbstx.com

Patient first name _____ Patient last name _____

Blue Cross ID number _____ Date of birth (MM/DD/YYYY) _____

Patient address _____ Patient phone (_____) _____

Requesting physician _____

Physician specialty _____ Physician UPIN# _____ Physician NPI# _____

Physician signature _____ Date _____

Physician (clinic name) and address _____

Phone (_____) _____ Fax (_____) _____

MEDICATION REQUESTED _____

1. Patient's diagnosis to be treated with requested medication _____
2. If the diagnosis is hepatitis C or hepatitis B, has the diagnosis been confirmed by lab testing for the detection of serologic markers for the infection? Yes No
3. Is the patient **currently being treated** with the requested medication? Yes No
If yes, when was treatment with the requested medication started? _____
4. Has the patient **completed in the past** a treatment course with interferon or peginterferon? Yes No
If yes, list dates (if known) _____
5. If the diagnosis is hepatitis C, has the HCV RNA level been checked after 6 months (24 weeks) of therapy to confirm therapeutic response? Yes No
If yes, is the HCV RNA level negative or decreased by two log₁₀ units? Yes No
6. If the diagnosis is hepatitis C, has peginterferon been prescribed as chronic maintenance therapy? Yes No
7. Please include any additional information that should be considered for review of this request _____

PLEASE FAX OR MAIL THIS FORM TO:
Blue Cross and Blue Shield of Texas
c/o Prime Therapeutics LLC, Clinical Review Department
1020 Discovery Road, No. 100
Eagan, Minnesota 55121

TOLL FREE:
Fax: 877.480.8130 Phone: 800.289.1525

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