



**BlueCross BlueShield
of Alabama**

An Independent Licensee of the Blue Cross and Blue Shield Association.

This form is for authorization of prescription drug benefits only and must be COMPLETELY filled out.

**SPECIAL PRESCRIPTION DRUG
FOR HEPATITIS COVERAGE
AUTHORIZATION REQUEST FORM**

GENERAL INFORMATION *Request Type (please check one)*

Prior Authorization Step Therapy Exception Appeal

Patient Name

Date of Birth (mm/dd/yyyy)

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Patient's Home Address

Contract Number (include prefix)

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City

State

Zip

PHYSICIAN INFORMATION

Physician Name

Practice Type

PCP Specialty: _____

Practice Address

Physician NPI

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City

State

Zip

Provider Number

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Office Phone

Office Fax

TREATMENT INFORMATION

Drug Requested: Pegasys® (Preferred) Peg-Intron® (Non-Preferred)

Dosage:

Disease State: Hepatitis C Hepatitis B

Patient Weight: kg lb.

Therapeutic Stage: Initiate Therapy Continue Therapy

Genotype: 1 2 3 4 5 6

For Hepatitis C:

Baseline Viral Level: _____ Date: _____

Viral Level at 12 Weeks: _____ Date: _____

Did Patient Demonstrate early virologic response: Undetectable HCV RNA titer 2 log (100 fold) reduction in HCV RNA titer

I certify this information is complete and correct to the best of my knowledge.

Physician Signature

Date

**SUBMISSION
INSTRUCTIONS**

FAX

You may fax the signed and completed form to Pharmacy Review at:
866 606-6021

MAIL

You may mail the signed and completed form to:
**Pharmacy Review
Post Office Box 3210
Auburn, AL 36831**