



Fax completed prior authorization request form to 855-247-3677 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/rbha-forproviders/pharmacy

Interferons Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information					
Member Name (first & last):		Date of Birth:		Gender:	
				<input type="checkbox"/> Male <input type="checkbox"/> Female	
Member ID:		City:		State:	
				Height:	
				Weight:	
Prescribing Provider Information					
Provider Name (first & last):		Specialty:		NPI#	
				DEA#	
Office Address:		City:		State:	
				Zip Code:	
Office Contact:			Office Phone		Office Fax:
Dispensing Pharmacy Information					
Pharmacy Name:			Pharmacy Phone:		Pharmacy Fax:
Requested Medication Information					
<input type="checkbox"/> Alferon N		<input type="checkbox"/> Intron A		<input type="checkbox"/> Pegasys	
				<input type="checkbox"/> Actimmune	
<input type="checkbox"/> Other, please specify:					
Are there any contraindications to formulary medications? If yes, please specify:				<input type="checkbox"/> Yes	<input type="checkbox"/> No
				<input type="checkbox"/> New request	<input type="checkbox"/> Continuation of therapy request
What medication(s) has member tried and failed for this diagnosis?					
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): Yes No		Diagnosis:		ICD-10 Code:	
Directions for Use:		Strength:		Dosage Form:	
		Quantity:	Day Supply:	Duration of Therapy/Use:	
Turn-Around Time for Review					
<input type="checkbox"/> Standard – (24 hours)			<input type="checkbox"/> Urgent – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision.		
			Signature: _____		
Clinical Information					
<input type="checkbox"/> Chronic Hepatitis B					
Current lab reports to support the following:		<input type="checkbox"/> Documentation ALT ≥2 times ULN		<input type="checkbox"/> Documentation of elevated Hepatitis B Virus DNA level	
		<input type="checkbox"/> Significant histologic disease		<input type="checkbox"/> Above 20,000 IU/mL Hepatitis B e-antigen positive	
				<input type="checkbox"/> Above 2,000 IU/mL Hepatitis B e-antigen negative	
Is there evidence of compensated Liver disease?					<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Renewal ONLY:					
Is lab report supportive of Hepatitis B e-antigen POSITIVE?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Is lab report supportive of Hepatitis B e-antigen NEGATIVE?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Follicular Non-Hodgkin's Lymphoma (Stage III/IV)					
Will requested medication be given in conjunction with anthracycline-containing combination chemotherapy?					<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS)-Related Kaposi's Sarcoma					
Confirm member age per above:			Confirm provider specialty per above:		
<input type="checkbox"/> Hairy-Cell Leukemia					
Did member have less than a complete response to cladribine or pentostatin?					<input type="checkbox"/> Yes <input type="checkbox"/> No

Was there a relapse after <2 years of demonstrating a complete response to cladribine OR pentostatin?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal ONLY:				
Is there evidence of disease progression?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Chronic Granulomatous Disease				
Confirm member age per above:		Confirm provider specialty per above:		
<input type="checkbox"/> Renewal ONLY:				
Is there evidence of disease progression?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Malignant Osteopetrosis				
Confirm diagnosis per above:		Confirm provider specialty per above:		
<input type="checkbox"/> Renewal ONLY:				
Is there evidence of disease progression?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Condylomata acuminata - Genital or Venereal Warts				
Is requested medication for intra-lesional use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are the lesions small and limited in number?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did member have trial and failure with TOPICAL treatments (for example, imiquimod cream, podofilox)?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was there trial and failure with a surgical technique (for example, cryotherapy, laser surgery, electrodesiccation, surgical excision)?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal ONLY:				
Was there at least 3 months between treatments, unless lesions grow, or new lesions appear?			<input type="checkbox"/> Yes	<input type="checkbox"/> No

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.
Standard turnaround time is 24 hours. You can call 800-564-5465 to check the status of a request.