Prior Authorization

AETNA BETTER HEALTH ILLINOIS (MEDICAID)

Intron A & Alferon N (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-855-684-5250**.
When conditions are met, we will authorize the coverage of Intron A & Alferon N (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

INTRON A solution for injection (interferon alfa-2b) INTRON A powder for solution (interferon alfa-2b)

ALFERON N (interferon alfa-n3)

Other, Please specify: _____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If yes, skip to question 25.]

2. Is this request for Alferon N? Y N

   [If yes, skip to question 21.]

3. Is this request for Intron A? Y N

[If no, then no further questions.]

4. Is Intron A prescribed by, or in consultation with an appropriate specialist based on the condition being treated? Y N

   List specialty:

   _____

   [If no, then no further questions.]

5. Does the patient have a diagnosis of chronic hepatitis B? Y N

   [If no, skip to question 13.]

6. Was the patient surface antigen positive (HBsAg positive) for more than six months? Y N

   [If no, no further questions.]

7. Is the patient e-antigen positive (HBeAg positive)? Y N

   [If no, skip to question 9.]

8. Does the patient have hepatitis B DNA levels greater than or equal to 20,000 IU/mL? Y N

   [If no, then no further questions.]

   [If yes, skip to question 10.]

9. Does the patient have hepatitis B DNA levels greater than or equal to 2,000 IU/mL? Y N

   [If no, then no further questions.]

10. Does the patient have compensated liver disease (e.g., normal bilirubin, albumin, hemoglobin, neutrophils, and platelets)? Y N

    [If no, then no further questions.]

11. Is there evidence of liver inflammation (e.g., ALT levels elevated to more than 2 times ULN (>2x ULN), inflammation or fibrosis on liver biopsy)? Y N

    [If no, then no further questions.]

12. Is the patient at least 1 year old? Y N

    [No further questions.]

13. Does the patient have a diagnosis of AIDS-related Kaposi's sarcoma? Y N

    [If no, skip to question 16.]

14. Is Intron A being used for the treatment of visceral AIDS-related Kaposi's sarcoma associated with rapidly progressive disease? Y N

    [If yes, no further questions.]

15. Is the request for the powder for solution formulation? Y N

    [If no, then no further questions.]

    [If yes, skip to question 24.]

16. Does the patient have a diagnosis of hairy cell leukemia? Y N

    [If no, skip to question 19.]

17. Does the patient meet ONE of the following criteria: A) Had less than complete response to cladribine or pentostatin; B) Had disease relapse within 1 year after a complete response to cladribine or pentostatin? Y N

    [If no, then no further questions.]

18. Does the patient have at least ONE of the following: A) Systemic symptoms – fatigue, weakness, weight loss, fever, night sweats; B) Symptomatic splenomegaly or adenopathy; C) Significant cytopenias – hemoglobin less than 12 g/dL, platelet count less than 100,000/mcL, or ANC less than 1500/mcL? Y N

    [If no, then no further questions.]

    [If yes, skip to question 24.]

19. Does the patient have a diagnosis of malignant melanoma? Y N

[If no, skip to question 21.]

20. Has the patient undergone surgical resection AND is at high risk for recurrence (e.g., primary tumor is more than 4 mm thick, presence of ulceration, and/or lymph node involvement)? Y N

    [If no, then no further questions.]

    [If yes, skip to question 24.]

21. Does the patient have a diagnosis of Condylomata acuminate (genital or venereal warts)? Y N

    [If no, then no further questions.]

22. Has the patient failed topical treatments or surgical techniques for the same lesion [e.g., cryotherapy, laser removal, surgical excision, electrodessication, imiquimod (Aldara) cream, Podofilox]? Y N

    If yes, list treatments tried and dates:

    _____

    [If no, then no further questions.]

23. Are the lesion(s) small in size and limited in number and this is prescribed for intralesional use? Y N

    [If no, then no further questions.]

24. Is the patient at least 18 years old? Y N

    [No further questions.]

25. Is the renewal request for Intron A? Y N

    [If no, skip to question 30.]

26. Is this a renewal request for Intron A for treatment of hepatitis B? Y N

    [If no, skip to question 29.]

27. Does the patient continue to be positive for hepatitis B e-antigen (HBeAG +)? Y N

    [If yes, then no further questions.]

28. Has the patient already received 2 years of treatment with Intron A? Y N

    [No further questions.]

29. Has the patient had a response to treatment? Y N

    [No further questions.]

30. Is this a renewal request for Alferon-N for treatment of genital or venereal warts? Y N

    [If no, then no further questions.]

31. Are the treatments at least 3 months apart? Y N

    [If yes, then skip to question 33.]

32. Does the patient have signs of disease progression? Y N

    [If no, then no further questions.]

33. Has the patient had a response to treatment? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date