09/25/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Peginterferon (IL88)

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 Medicaid at **1-844-242-0908**.
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Peginterferon (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

PEG-Intron (peginterferon alfa-2b) Pegasys (peginterferon alfa-2b)

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: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

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

   [If yes, skip to question 13: REAUTHORIZATION REQUESTS]

2. INITIAL AUTHORIZATION REQUESTS: Is therapy prescribed by, or in consultation with a gastroenterologist, hepatologist, transplant physician, HIV specialist, or infectious diseases specialist? Please document prescriber specialty: Y N

   [If no, no further questions.]

3. Does the patient have any of the following? Y N

   Alcohol or illicit drug use during the last 6 months \ Autoimmune hepatitis \ Decompensated hepatic disease (Child-Pugh score greater than 6) \ Severe untreated depression \ Severe anemia, neutropenia, or thrombocytopenia \ Severe renal dysfunction \ For patients who are prescribed Peg-Intron: age less than 3 years \ For patients who are prescribed Pegasys: age less than 5 years

   [If yes, no further questions.]

4. Is treatment prescribed for a diagnosis of chronic hepatitis B (HBV) infection? Y N

   [If yes, skip to question 42.]

5. Is treatment prescribed for a diagnosis of chronic hepatitis C (HCV) infection? Y N

   [If no, no further questions.]

6. Have recent (within the last 3 months) baseline viral levels (HCV-RNA) been drawn? If yes, please document HCV-RNA and date drawn: Y N

   [If no, no further questions.]

7. Is the HCV genotype 2 or 3? If yes, please document genotype: Y N

   [If no, skip to question 9.]

8. Is the patient co-infected with HIV? Y N

   [No further questions.]

9. Is the HCV genotype 1, 4, 5, or 6? Please document genotype Y N

   [If no, no further questions.]

10. Does the patient meet ALL of the following? Note to provider: PA for Incivek must be requested separately Y N

    HCV genotype 1 AND \ Will be treated with concomitant Incivek therapy

    [If yes, no further questions.]

11. Does the patient meet ALL of the following? Note to provider: PA for Victrelis must be requested separately Y N

    HCV genotype 1 AND \ Will be treated with concomitant Victrelis therapy

    [If yes, no further questions.]

12. Has the patient received a prior course of treatment with the requested regimen (i.e., prior relapsers, partial responders or non-responders)? Y N

    [No further questions]

13. REAUTHORIZATION REQUESTS: Is the request for a Genotype 1 patient receiving triple therapy with Incivek? Y N

    [If yes, skip to question 21.]

14. Is the request for a Genotype 1 patient receiving triple therapy with Victrelis? Y N

    [If yes, skip to question 30.]

15. Is the request for a patient with Genotype 1, 4, 5, or 6 who is receiving dual therapy? Y N

    [If no, no further questions.]

16. Has the patient completed at least 12 weeks of therapy? Please document actual treatment start date: Y N

    [If no, no further questions.]

17. Is the patient's treatment week 12 (TW12) HCV-RNA UNDETECTABLE? Y N

    [If yes, no further questions.]

18. Is the patient's TW12 HCV-RNA level at least a 2-log (100-fold) drop from the pretreatment level? Please document Pretreatment HCV-RNA, treatment week 12 (TW12) HCV-RNA, and date drawn: Y N

    [If no, no further questions.]

19. Has the patient completed at least 24 weeks of therapy? Y N

    [If no, no further questions.]

20. Is the patient's treatment week 24 (TW24) HCV-RNA level undetectable? Please document HCV-RNA and date drawn: Y N

[No further questions.]

21. REAUTHORIZATION REQUESTS - GENOTYPE 1 - TRIPLE THERAPY WITH INCIVEK: Have the treatment week 4 (TW4) HCV-RNA levels been drawn? Please document actual treatment start date: Y N

[If no, no further questions.]

22. (Incivek patients) Is the patient's treatment week 4 (TW4) HCV-RNA level either undetectable or less than or equal to 1000 IU/ml? Please document treatment week 4 (TW4) HCV-RNA, and date drawn Y N

[If no, no further questions.]

23. (Incivek patients) Has the patient completed at least 12 weeks of therapy? Y N

[If no, no further questions.]

24. (Incivek patients) Have the treatment week 12 (TW12) HCV-RNA levels been drawn? Y N

[If no, no further questions.]

25. (Incivek patients) Is the patient's treatment week 12 (TW12) HCV-RNA level either undetectable or less than or equal to 1000 IU/ml? Please document HCV-RNA and date drawn: Y N

[If no, no further questions.]

26. (Incivek patients) Does the patient meet ALL of the following: Y N

Treatment naïve or relapser \ No cirrhosis \ Treatment week 4 (TW4) HCV-RNA undetectable \ Treatment week 12 (TW12) HCV-RNA undetectable

[If yes, no further questions.]

27. Has the patient completed at least 24 weeks of therapy? Y N

[If no, no further questions.]

28. Is the patient's treatment week 24 (TW24) HCV-RNA level undetectable? Please document HCV-RNA and date drawn: Y N

    [If no, no further questions.]

29. (Incivek patients) Does patient meet all of the following: Y N

    Treatment naïve or relapser \ No cirrhosis \ Treatment week 4 (TW4) HCV-RNA undetectable \ Treatment week 12 (TW12) HCV-RNA undetectable \ Treatment week 24 (TW24) HCV-RNA undetectable

    [No further questions]

30. REAUTHORIZATION REQUESTS - GENOTYPE 1 - TRIPLE THERAPY WITH VICTRELIS: Has the patient completed at least 8 weeks* of therapy? Please document actual treatment start date: Y N

    (*4 weeks of lead-in treatment with peg-interferon +ribavirin, followed by 4 weeks of triple therapy with Victrelis)

    [If no, no further questions.]

31. Victrelis patients - Have the treatment week 8 (TW8)* HCV-RNA levels been drawn? If yes, Please document HCV-RNA and date drawn: Y N

    (*4 weeks of lead-in treatment with peg-interferon +ribavirin, followed by 4 weeks of triple therapy with Victrelis)

    [If no, no further questions.]

32. Victrelis patients - Has the patient completed greater than 12 weeks* of therapy? Y N

    (*4 weeks of lead-in treatment with peg-interferon +ribavirin, followed by 8 weeks of triple therapy with Victrelis)

    [If no, no further questions.]

33. Victrelis patients - Have the treatment week 12 (TW12) HCV-RNA levels been drawn? Y N

    [If no, no further questions.]

34. Victrelis patients - Is the patient's treatment week 12 (TW12) HCV-RNA level either undetectable or less than 100 IU/ml? Please document HCV-RNA and date drawn: Y N

[If no, no further questions.]

35. Victrelis patients - Have the treatment week 24 (TW24) HCV-RNA levels been drawn? Y N

[If no, no further questions.]

36. Victrelis patients - Is the patient's treatment week 24 (TW24) HCV-RNA level undetectable? Please document HCV-RNA and date drawn: Y N

[If no, no further questions.]

37. Victrelis patients - Does the patient meet one of the following? Y N

Patient has cirrhosis, OR \ Patient is a previous null responder. +

[If yes, no further questions.]

38. Victrelis patients - Is patient treatment naïve? Y N

[If yes, skip to question 40.]

39. Victrelis patients - Is patient a previous partial responder or relapser? Y N

[If no, no further questions.]

40. Victrelis patients - Are HCV-RNA levels at treatment week 8 (TW8) and treatment week 24 (TW24) undetectable? Y N

[If yes, no further questions.]

41. Victrelis patients - Are HCV-RNA levels at treatment week 8 (TW8) DETECTABLE and HCV-RNA levels at treatment week 24 (TW24) UNDETECTABLE? Y N

[No further questions.]

42. Is the requested drug Pegasys? Y N

[If no, no further questions.]

43. Does the patient meet all of the following? Provider - please provide laboratory results

Y N

Diagnosis of HBeAg-positive or HBeAg-negative Chronic Hepatitis B, AND \ Compensated liver disease, AND \ Evidence of viral replication and liver inflammation, AND \ Patient is at least 18 years old

Comments:

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

Prescriber (Or Authorized) Signature Date