

Pharmacy Prior Authorization Form

Last Reviewed: Jan. 10

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Infergen (interferon alfacon-1) Urgent Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

Infergen Injection 9 mcg

Infergen Injection 15 mcg

Dose: _____ Start date: _____

Priority Health Precertification Requirements:

Authorization of Increlex requires:

- Diagnosis of chronic hepatitis C
- Documented therapeutic trial of Pegylated Interferon
- Recommended dose is 9 mcg three times per week

Please Complete the Following Information:

Diagnosis:

Chronic Hepatitis B

Other: _____ Please provide rationale for use:

Patient's age: _____

Patient's Genotype: _____

New request or continuation of therapy:

New request

Continuation of therapy

Documented therapeutic trial and clinical of Pegylated Interferon:

Yes

No – Rationale for use: _____

Patient will be self injecting:

Yes

No

*** All fields must be complete and legible for Prior Authorization Review***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX