PriorityHealth

Pharmacy
Prior Authorization Form

Last Reviewed: Jan. 12

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