Prescription Drug Coverage Determination Form

Antiviral

Rebetol® (ribavirin oral solution), Ribasphere®, Ribapak®, Ribatab® and ribavirin

Please fax the completed form to Mercy Health Plans' Pharmacy Department
at 314-214-8201 or 1-800-466-9854.

Patient Information

Patient Name: ________________ Date of Birth:___________________

Subscriber ID#: ___________________

Address_______________________City_______________State____Zip Code________

Physician Information

Name: _______________________ Specialty:____________Tax ID#: _______________

Office Address_______________________City__________State____Zip Code________

Telephone: _________________ Fax:___________________Contact Person____________

Physician Signature (REQUIRED):_____________________________Date___________

Medication Information (requests for non-formulary agents will be considered for members having a documented failure or contraindication to preferred agents.)

Medication name:___________________ J-code:______________

Dose:___________________________________ Directions:_________________________

Expected Duration of Therapy:______________________

Prior Authorization Criteria:

1. Is the medication being requested to treat an FDA-approved indication not otherwise excluded from Part D? □ Yes □ No
   Diagnosis: ______________________________ ICD-9 code________________
2. Will the patient be taking an alfa interferon product (e.g. Intron A, Roferon A, Pegasys, PEG-Intron) concurrently with ribavirin therapy? □ Yes □ No
3. Does the patient have detectable levels of hepatitis C RNA (a viral load) in the serum? □ Yes □ No
4. Has the patient received up to 4 months of ribavirin therapy previously? □ Yes □ No
   If yes:
   - Did the patient have detectable levels of Hepatitis C RNA (a viral load) in the serum after or at the end of the initial treatment period? □ Yes □ No
   - Did the patient show a 2-log decrease in viral load? □ Yes □ No
5. Does the patient have a history of unstable heart disease? □ Yes □ No
6. Does the patient have a hemoglobin <8.5 g/dL? □ Yes □ No
7. Does the patient have a creatinine clearance less than 50 ml/min? □ Yes □ No

Y0047_6015 v2 4_10
Approved 4/20/2010

8. If the patient is male, is the partner of the patient pregnant?	□ Yes □ No
9. Is the patient a female of childbearing potential?	□ Yes □ No
If yes:	
▪ Has pregnancy been excluded by a negative urine or serum pregnancy test?	□ Yes □ No
9. Does the patient have the diagnosis of a hemoglobinopathy, such as thalassemia major or sickle-cell anemia?	□ Yes □ No

Please provide any additional history or medical information that may support coverage (attach office notes as necessary): ____

____

Note: If approved coverage will be as specified in above criteria or through the end of the year (December 31, 20xx). Some medications may be subject to quantity limitations or restricted to certain pharmacies.