OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Pegasys® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Chronic hepatitis B
❑ Chronic hepatitis C
❑ Other diagnosis: _____ ICD-10 Code(s): _____

For chronic hepatitis B, answer the following:

Does the patient have decompensated liver disease? ❑ **Yes** ❑ **No**

For chronic hepatitis C, answer the following:

Does the patient have decompensated liver disease? ❑ **Yes** ❑ **No**

Select if Pegasys will be used in combination with the following:

❑ Olysio (simeprevir)
❑ Sovaldi (sofosbovir)
❑ Ribavirin

Is Pegasys being used as monotherapy? ❑ **Yes** ❑ **No**

If "yes" to the above question, is there contraindication or intolerance to all other hepatitis C virus agents [e.g., Olysio (simeprevir), Sovaldi (sofosbuvir), ribavirin]? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request for hepatitis C, answer the following questions:

Does the patient have an undetectable HCV RNA level at week 24? ❑ **Yes** ❑ **No**

Are additional treatment weeks of peginterferon required to complete treatment regimen? ❑ **Yes** ❑ **No**

Has the patient exceeded 48 weeks of therapy with peginterferon? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Pegasys_CMS_2018Feb-W