



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

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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 <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information <small>(required)</small>			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information <small>(required)</small>	
Select the diagnosis below:	
<input type="checkbox"/> Chronic hepatitis B	
<input type="checkbox"/> Chronic hepatitis C	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
For chronic hepatitis B, answer the following:	
Does the patient have decompensated liver disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	
For chronic hepatitis C, answer the following:	
Does the patient have decompensated liver disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Select if Pegasys will be used in combination with the following:	
<input type="checkbox"/> Olysio (simeprevir)	
<input type="checkbox"/> Sovaldi (sofosbuvir)	
<input type="checkbox"/> Ribavirin	
Is Pegasys being used as monotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> 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]? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are additional treatment weeks of peginterferon required to complete treatment regimen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the patient exceeded 48 weeks of therapy with peginterferon? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

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