

Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Intron A & Alferon N (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.

Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-844-242-0908**.

When conditions are met, we will authorize the coverage of Intron A & Alferon N (Medicaid).

Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (please circle)

INTRON A solution for injection (interferon alfa-2b)    INTRON A powder for solution (interferon alfa-2b)

ALFERON N (interferon alfa-n3)

Other, Please specify: \_\_\_\_\_

Quantity \_\_\_\_\_                      Frequency \_\_\_\_\_                      Strength \_\_\_\_\_

Route of Administration \_\_\_\_\_                      Expected Length of therapy \_\_\_\_\_

Patient Information

Patient Name: \_\_\_\_\_  
Patient ID: \_\_\_\_\_  
Patient Group No.: \_\_\_\_\_  
Patient DOB: \_\_\_\_\_  
Patient Phone: \_\_\_\_\_

Prescribing Physician

Physician Name: \_\_\_\_\_  
Specialty: \_\_\_\_\_                      NPI Number: \_\_\_\_\_  
Physician Fax: \_\_\_\_\_                      Physician Phone: \_\_\_\_\_  
Physician Address: \_\_\_\_\_                      City, State, Zip: \_\_\_\_\_

Diagnosis: \_\_\_\_\_                      ICD Code: \_\_\_\_\_

Please circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?                      Y                      N  
    [If yes, skip to question 25.]
2. Is this request for Alferon N?                      Y                      N  
    [If yes, skip to question 21.]
3. Is this request for Intron A?                      Y                      N

[If no, then no further questions.]

4. Is Intron A prescribed by, or in consultation with an appropriate specialist based on the condition being treated? Y N

List specialty:

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[If no, then no further questions.]

5. Does the patient have a diagnosis of chronic hepatitis B? Y N

[If no, skip to question 13.]

6. Was the patient surface antigen positive (HBsAg positive) for more than six months? Y N

[If no, no further questions.]

7. Is the patient e-antigen positive (HBeAg positive)? Y N

[If no, skip to question 9.]

8. Does the patient have hepatitis B DNA levels greater than or equal to 20,000 IU/mL? Y N

[If no, then no further questions.]

[If yes, skip to question 10.]

9. Does the patient have hepatitis B DNA levels greater than or equal to 2,000 IU/mL? Y N

[If no, then no further questions.]

10. Does the patient have compensated liver disease (e.g., normal bilirubin, albumin, hemoglobin, neutrophils, and platelets)? Y N

[If no, then no further questions.]

11. Is there evidence of liver inflammation (e.g., ALT levels elevated to more than 2 times ULN (>2x ULN), inflammation or fibrosis on liver biopsy)? Y N

[If no, then no further questions.]

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|---|---|---|
| 12. Is the patient at least 1 year old?   | Y | N |
| [No further questions.]   |   |   |
| 13. Does the patient have a diagnosis of AIDS-related Kaposi's sarcoma?   | Y | N |
| [If no, skip to question 16.]   |   |   |
| 14. Is Intron A being used for the treatment of visceral AIDS-related Kaposi's sarcoma associated with rapidly progressive disease?   | Y | N |
| [If yes, no further questions.]   |   |   |
| 15. Is the request for the powder for solution formulation?   | Y | N |
| [If no, then no further questions.]   |   |   |
| [If yes, skip to question 24.]  |   |   |
| 16. Does the patient have a diagnosis of hairy cell leukemia?   | Y | N |
| [If no, skip to question 19.]   |   |   |
| 17. Does the patient meet ONE of the following criteria:<br>A) Had less than complete response to cladribine or pentostatin; B) Had disease relapse within 1 year after a complete response to cladribine or pentostatin?   | Y | N |
| [If no, then no further questions.]   |   |   |
| 18. Does the patient have at least ONE of the following:<br>A) Systemic symptoms – fatigue, weakness, weight loss, fever, night sweats; B) Symptomatic splenomegaly or adenopathy; C) Significant cytopenias – hemoglobin less than 12 g/dL, platelet count less than 100,000/mcL, or ANC less than 1500/mcL? | Y | N |
| [If no, then no further questions.]   |   |   |
| [If yes, skip to question 24.]  |   |   |
| 19. Does the patient have a diagnosis of malignant melanoma?  | Y | N |

[If no, skip to question 21.]

20. Has the patient undergone surgical resection AND is at high risk for recurrence (e.g., primary tumor is more than 4 mm thick, presence of ulceration, and/or lymph node involvement)? Y N

[If no, then no further questions.]

[If yes, skip to question 24.]

21. Does the patient have a diagnosis of Condylomata acuminata (genital or venereal warts)? Y N

[If no, then no further questions.]

22. Has the patient failed topical treatments or surgical techniques for the same lesion [e.g., cryotherapy, laser removal, surgical excision, electrodesiccation, imiquimod (Aldara) cream, Podofilox]? Y N

If yes, list treatments tried and dates:

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[If no, then no further questions.]

23. Are the lesion(s) small in size and limited in number and this is prescribed for intralesional use? Y N

[If no, then no further questions.]

24. Is the patient at least 18 years old? Y N

[No further questions.]

25. Is the renewal request for Intron A? Y N

[If no, skip to question 30.]

26. Is this a renewal request for Intron A for treatment of hepatitis B? Y N

[If no, skip to question 29.]

27. Does the patient continue to be positive for hepatitis B e-antigen (HBeAG +)? Y N

[If yes, then no further questions.]

28. Has the patient already received 2 years of treatment with Intron A? Y N

[No further questions.]

29. Has the patient had a response to treatment? Y N

[No further questions.]

30. Is this a renewal request for Alferon-N for treatment of genital or venereal warts? Y N

[If no, then no further questions.]

31. Are the treatments at least 3 months apart? Y N

[If yes, then skip to question 33.]

32. Does the patient have signs of disease progression? Y N

[If no, then no further questions.]

33. Has the patient had a response to treatment? Y N

Comments:

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I affirm that the information given on this form is true and accurate as of this date.

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Prescriber (Or Authorized) Signature

Date