

**Pegasys® (pegylated interferon alpha)/Ribavirin**  
**Certificate of Medical Necessity**  
**6-Month Follow-Up**

**PLEASE FILL IN ALL INFORMATION REQUESTED**

**Patient Name:** \_\_\_\_\_ **GHI ID #:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Weight (kg):** \_\_\_\_\_

**Diagnosis:**       **Chronic Hepatitis B**                       **Chronic Hepatitis C**

**Viral GENOTYPE result \*:** \_\_\_\_\_

**Viral Load prior to PEG-IFN treatment ◆\*:** \_\_\_\_\_ copies/ml    **Date Viral Load obtained ◆\*:** \_\_\_\_\_

**Viral Load @ 6 months of therapy ◆\*:** \_\_\_\_\_ copies/mL    **Date viral load obtained\*:** \_\_\_\_\_

**HBeAg ◆:**     **positive**     **negative**                      **HBsAg ◆**                          **Date of results:** \_\_\_\_\_ (optional)

**Serum Alanine Aminotransferase (ALT) ◆ :** \_\_\_\_\_ units/liter (U/L)    **Date of test:** \_\_\_\_\_

**Serum Alanine Aminotransferase (ALT) @ 6 months of therapy ◆ :** \_\_\_\_\_ units/liter (U/L)

**Other pertinent medical information:** \_\_\_\_\_

**Pegasys® dose requested ◆\*:** \_\_\_\_\_

**Ribavirin dose requested\*:** \_\_\_\_\_

**Prescribing Physician** \_\_\_\_\_ **License #** \_\_\_\_\_

**Telephone #** \_\_\_\_\_ **Fax#** \_\_\_\_\_

**CRITERIA FOR CONTINUED COVERAGE BEYOND 6 MONTHS (UP TO 1 YEAR)**

- 1.** Patient with eligible prescription benefit
- 2.** Patient with Hepatitis C viral (HCV) genotype of 1, 4, 5, 6.
- 3.** Patient with HCV-RNA that is *undetectable*, continue therapy for an additional 6 months
- 4.** Patient with HBV that obtained normalization of ALT and suppression of HBV-RNA below 20,000 c/mL

***Please complete the form and fax to:***

Director, Clinical Pharmacy Programs  
GHI/GHI HMO Pharmacy Services  
55 Water Street, 12<sup>th</sup> Floor South  
New York, NY 10041  
Phone: 1-877-444-3657

**Fax: (877) 300-9695**