Prior Authorization Request Form for Rebetol (ribavirin oral capsule and solution), Copegus (ribavirin oral tablet), and Ribasphere (ribavirin oral capsule)

Member Information

Patient Name _____
Cardholder ID _____
Date of Birth _____
Address _____
City, State Zip _____
Phone Number _____

Provider Information

Provider Name _____
DEA Number _____
Address _____
City, State and Zip _____
Phone Number _____
FAX Number _____

Pharmacy Information

Pharmacy Name_____Address_____Phone_____

Criteria for Approval:

1. Ribavirin drug requested? *Check one:* Rebetol caps ☐ Copegus ☐ Ribasphere ☐ Rebetol Solution ☐
2. Does the patient have a diagnosis of chronic hepatitis C with signs present and demonstrated on liver biopsy? Yes ☐ No ☐
3. Does the patient have a history of heart disease? Yes ☐ No ☐
4. Does the patient have: *Check all that apply:*
   Hemoglobin > 8.5 gm/dL ☐ Creatinine clearance ≥ 50 ml/min/1.73m² ☐
5. Does the patient have: *Check all that apply:*
   Detectable levels of hepatitis C virus (HCV) RNA in the serum ☐
   Persistently elevated serum alanine aminotransferase (ALT) levels > 2 times the upper limit ☐
6. Is the patient: *Check one:*
   Female and pregnant or planning to become pregnant ☐
   Male with a partner that is planning to become pregnant ☐
7. Has or will the patient be instructed to practice effective contraceptives during therapy and six months after therapy with ribavirin therapy? Yes ☐ No ☐
8. Has the patient received interferon therapy within the previous year? Yes ☐ No ☐
9. Did the patient respond to the previous interferon therapy? Yes ☐ No ☐
10. Will the patient be on Intron A or Pegasys concurrently with ribavirin? Yes ☐ No ☐
11. Will the patient be monitored for depression during therapy? Yes ☐ No ☐
12. Will the hemoglobin levels be monitored during therapy? Yes ☐ No ☐
13. Is the patient being treated for relapse after monotherapy with an interferon product? Yes ☐ No ☐
14. If the patient has relapsed or did not respond to previous interferon therapy, will the patient be restarted on a higher dose regimen as labeling recommends? Yes ☐ No ☐

Provider Signature _____ Date _____

Fax completed forms to (866) 284-4509.

For Office Use Only
Date/Time Received_____
Reference Number_____
Approved / Denied (Circle One) by _____ Date _____
Date/Time Returned to Provider_____

If you have any questions regarding this form, contact the Prior Authorization Department Toll Free at (866) 284-4492 or FAX Toll Free at (866) 284-4509.

FOX Rx Care Utilization Management
3375-I Capital Circle NE
Tallahassee, FL 32308

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