

Intron-A **Intron-A (Interferon alfa-2b). Patients must have one of the following conditions with corresponding criteria:**

AIDS related Kaposi's Sarcoma- HIV positive, disease limited to the skin, CD4 lymphocyte count \geq 200 cells/mm3. CD4 count _____ [6 months]

Chronic Hepatitis B- HBeAg positive- ALT > 2 times normal or diagnosis of moderate to severe hepatitis on biopsy. LFT _____ [4 months]

Chronic Hepatitis B- HBeAg negative- Serum HBV DNA >100,000 copies/ml with either ALT > 2 times normal or moderate to severe hepatitis on biopsy. LFT _____ HBVDNA _____ copies/ml. [12 months]

Chronic Hepatitis C- Diagnosis confirmed by liver biopsy, patient \geq 18 years of age, patient does not have decompensated liver disease, detectable HCV RNA viral level _____ copies/ml; genotype 1 or 4 [12 weeks], genotype 2 or 3 [12 weeks]; reevaluate- baseline HCV RNA _____ current HCV RNA _____, level is undetectable or decreased by at least 2-log; genotype 1 or 4 [36 weeks], genotype 2 or 3 [12 weeks].

Conyomatata acuminata (Genital Warts)- Failure of at least one other method. [4 months]

Follicular Lymphoma- Patient currently receiving anthracycline containing chemotherapy regimen and at least one of the following: threatened end organ function, cytopenia secondary to lymphoma, massive bulk at presentation, steady progression > 6 months. ANC _____ Platelet _____ Initial treatment [6 months], reevaluate [6 months], not to exceed 18 months of therapy.

Hairy Cell Leukemia (HCL)- Active or repeated infection OR high risk of febrile neutropenia OR intolerant or resistant to nucleoside analogs OR significant neutropenia OR significant anemia OR significant thrombocytopenia OR symptomatic splenomegaly OR constitutional symptoms of HCL (fever, night sweats). Initial- Platelet _____ Hemoglobin _____ Granulocyte _____ [6 months] Reevaluation [6 months]

Malignant Melanoma- \geq 18 years old AND stage III or stage IIB melanoma AND currently disease free but at high risk for systemic recurrence AND used as adjuvant therapy within 56 days of surgery. LFT _____ Granulocyte _____ [12 months]

Member Information

Relationship (Circle)

Name _____

rollment / Cardholder ID _____

Group / Plan _____

Birth date _____

Address: _____

City State Zip _____

Subscriber Spouse Dependent

Gender (Circle)

Male Female

AGE: _____ Weight (kg): _____

Practitioner Information

Name _____

Agent / Contact Name _____

Specialty _____

Office / Clinic Name _____

Address _____

City State Zip _____

Phone () - _____

Fax () - _____

ID Number _____

Email _____ @ _____

Notes:

Requested Drug / Pharmaceutical

Intron-A (Interferon alfa-2b)

Strength / Dose

Therapy Start Date

Duration of Therapy (Expected)

Type of Request (Circle)

One-Time On-Going

Condition / Diagnosis Related - Reason for Request

Clinical Drug / Lab History Pertinent to Request

Labs: _____ Baseline / Ongoing _____

Formulary Alternative(s) Attempted YES NO (Circle)

Please List:

Contact Pharmacy? Y N

Pharmacy Phone Number

Practitioner Signature _____