

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

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**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].

**Chronic Myelogenous Leukemia (CML)**- Chronic phase; Philadelphia chromosome (PH) positive and within one year of diagnosis. WBC \_\_\_\_\_ [6 months]

**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]

**Member Information**

Name \_\_\_\_\_

Enrollment / Cardholder ID \_\_\_\_\_

Group / Plan \_\_\_\_\_

Birth date \_\_\_\_\_

Address: \_\_\_\_\_

City State Zip \_\_\_\_\_

**Relationship** (Circle)

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**

**Roferon-A (Interferon alfa-2a)**

**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