Main Office:

Scottsdale Vein & Proctology Center
8752 E Via De Commercio #2
Scottsdale, Arizona 85258
Office: (602) 492-9919 | Mobile: (602) 920-1023

RICK A SHACKET
DO, MD(H)

Name: _____ DOB: _____ Date: _____

DISPENSE ONE OF THE FOLLOWING FOUR PRESCRIPTIONS:

INTRON® A Powder for Injection (Single-dose)

❑ INTRON A Powder for Injection, 10 million IU per vial and Diluent for INTRON A (Sterile Water for Injection USP) 1 mL per vial; 10 MIU/mL, boxes containing 1 INTRON A vial and 1 vial of INTRON A Diluent (NDC 0085-0571-02). [About $322 or 32.20 a unit]

❑ If more than 1 vial is dispensed, Dispense ____ Vials

INTRON A Solution for Injection in Vials (Multi-dose)

❑ INTRON A Solution for Injection, 18 million IU multidose vial, 6 MIU/mL (22.8 million IU per 3.8 mL per vial); boxes containing 1 vial of INTRON A Solution for Injection (NDC 0085-1168-01). [Costco $437 or 24.27 unit]

❑ INTRON A Solution for Injection, 25 million IU multidose vial, 10 MIU/mL (32 million IU per 3.2 mL per vial); boxes containing 1 vial of INTRON A Solution for Injection (NDC 0085-1133-01). [Costco $990 or 39.60 unit]

Treatment Protocol: The recommended dose is 1.0 million IU per lesion in a maximum of 5 lesions in a single course. The lesions should be injected two or three times weekly on alternate days for 3 to 4 weeks. An additional course may be administered at 12 to 16 weeks.

Directions: For the intralesional treatment of refractory or recurring external condylomata acuminate (ICD10 Diagnosis Code A63.0), as directed by physician.

_____

Rick A. Shacket, DO, MD (H), BS9262611
Diplomate American Osteopathic Board of Proctology

Interferon Informed Consent

Side effects of interferon alfa-2b

What Is Interferon Alfa-2B?

Interferon alfa-2b belongs to a group of drugs called interferons. This medication works by stopping viruses from dividing and by triggering our immune system to kill invading pathogens or tumors. Interferon alfa-2b is made from human proteins. Interferons help your body's immune system respond to bacteria, viruses, cancer, or other invading substances.

Along with its needed effects, Interferon alfa-2b may cause some unwanted effects. Most of the side effects listed below probably won't occur, and if they do, may need medical attention.

Primary Care Physician

Attached to this informed consent are two full pages of potential side effects and two pages of instructions for your primary care provider (PCP). Therefore, we require that you see your PCP regularly, first to draw some baseline labs, and then to monitor you and your blood labs on a regular basis for potential complications. We have included a note to your PCP so that he or she understands what it is we want him to do. Unfortunately, we cannot afford to police your compliance to follow-up with your PCP. Please tell your Interferon doctor immediately if you are unable to or choose not to follow-up with a PCP physician, so that your interferon treatments may be delayed or rescheduled for another time.

FOR YOUR INFORMATION: We start most all patients on the lowest dose of interferon alfa-2b therapy, ≤ 3 million units per treatment, so reported side effects are usually at a minimum. Side effects are reported 3% of the time for 1 million units, 83% for 3million units, and 100% for 5 million units.

Influenza-like symptoms (mainly **fever, headache, rigors/chills, myalgia, malaise, and fatigue**) were reported most often; usually beginning 3–6 hours after injection and may last 8 to 24 hours.

Most side effects reported during clinical trials were mild to moderate in severity and manageable. Some side effects were transient and most diminished with continued therapy. **These side effects were reversible within 72 hours** after interrupting or stopping therapy. In general, more severe toxicities were observed at higher doses.

- Using this medicine will not prevent your disease from spreading. Follow your doctor's instructions about how to prevent passing the disease to another person.
- Avoid drinking alcohol. It may increase your risk of liver damage. Avoid driving or hazardous activity until you know how this medicine will affect you. Your reactions could be impaired.

Proper Use and Storage

Use a disposable needle and syringe only once. Store this medicine in the refrigerator. Do not freeze. After mixing the powder with a diluent, store this mixture in the refrigerator and use the first dose within 24 hours. Throw away any leftover medicine in a multi-dose vial 30 days after it is mixed.

I certify that I have read or had read to me the contents of this form. I understand that there are risks and alternatives to interferon therapy and have had those explained to me. I agree to be under the care of a PCP before, during, & after treatment. If I feel uncomfortable for any reason, I have the right to refuse treatment.

SIGNED: _____

WITNESS: _____ DATE: _____

SIDE EFFECTS THAT USUALLY DO NOT NEED MEDICAL ATTENTION

Some side effects of interferon alfa-2b may occur that usually do not need medical attention. These side effects may go away during treatment as your body adjusts to the medicine.

More Common

- Acid or sour stomach
- bleeding gums
- blistering, crusting, irritation, itching, or reddening of the skin
- body aches or pain
- burning, crawling, itching, numbness, prickling, "pins and needles", or tingling feelings
- change in taste, or bad, unusual, or unpleasant (after) taste
- cracked, dry, or scaly skin
- hair loss or thinning of the hair
- irritation in the mouth
- joint pain
- lack or loss of strength
- loss of memory
- muscle or bone pain
- pain or tenderness around the eyes and cheekbones
- poor concentration
- problems with memory
- redness and swelling of the gums
- stuffy or runny nose
- swollen joints

Less Common

- Abnormal ejaculation
- absent, missed, or irregular menstrual periods
- bleeding, burning, inflammation, itching, or pain at the injection site
- bone deformity
- burning, itching, and pain in the hairy areas, pus at the root of the hair
- burning, numbness, pain, or tingling in all fingers except smallest finger
- cold and clammy skin
- decrease in height
- decreased interest in sexual intercourse
- degenerative disease of the joint
- difficulty with moving or walking
- discoloration of the skin
- inability to have or keep an erection
- increased clear or white vaginal discharge
- increased sensitivity of the skin to sunlight
- itching or pain of the genital area
- leg cramps
- longer menstrual periods
- loss in sexual ability, desire, drive, or performance
- multiple swollen and inflamed skin lesions
- pain in the ankles or knees
- pain in the ribs
- pain, inflammation, or swelling in the calves, shoulders, or hands
- painful, red lumps under the skin, mostly on the legs
- pelvic pain
- rash with flat lesions or small raised lesions on the skin
- red or irritated eyes
- redness or swelling in the arms or legs
- redness, tenderness, itching, burning, or peeling of the skin
- severe sunburn
- shivering
- skin rash, encrusted, scaly, and oozing small lumps under the skin
- small lumps under the skin
- soreness of the muscles
- stopping of menstrual bleeding
- swelling or redness in the joints
- tanning or blue-gray discoloration of the skin
- tearing of the eyes
- underactive reflexes
- unexpected menstrual bleeding

SIDE EFFECTS THAT NEED IMMEDIATE MEDICAL ATTENTION

Although not all these side effects may occur, if they do occur they may need medical attention.

More Common

- Depression
- difficult or labored breathing
- swelling or puffiness of the face
- tightness in the chest
- weight loss

Less Common

- Back, leg, or stomach pains
- bleeding, tender, or enlarged gums
- bloody, black, or tarry stools
- bloody nose
- bloody or cloudy urine
- blurred vision
- change in personality
- changes in behavior
- chest pain, discomfort, or heaviness
- chills
- clay-colored stools
- confusion as to time, place, or person
- constipation
- cough producing mucus
- coughing or spitting up blood
- dark urine
- decreased urination
- diarrhea
- difficult or painful urination
- dizziness, faintness, or lightheadedness when getting up suddenly from a lying or sitting position
- drowsiness
- fainting
- fast, slow, pounding, irregular, or racing heartbeat or pulse
- feeling, seeing, or hearing things that are not there
- feeling that others are watching you or controlling your behavior
- feeling that others can hear your thoughts
- fever
- hallucinations
- headache
- hearing loss
- heavier menstrual periods
- hives or rash
- hoarseness or husky voice
- inability to speak
- increased thirst
- increased urination
- indigestion
- irritability
- itching, pain, redness, or swelling of the skin
- light-colored stools
- lightheadedness
- loss of appetite
- loss of consciousness
- loss of hearing
- lower back or side pain
- metallic taste
- muscle aches or cramps
- nausea or vomiting
- pale skin
- passing of gas
- pinpoint red spots on the skin
- seizures
- severe mood or mental changes
- severe stomach pain with nausea and vomiting
- slow speech
- sneezing
- sores, ulcers, or white spots on the lips or tongue or inside the mouth
- stiffness of the limbs
- stomach cramps, tenderness, or discomfort
- stomach pain, continuing
- stomach upset
- sweating
- swelling around the eyes
- swelling of the face, fingers, hands, ankles, feet, or lower legs
- swollen, painful, or tender lymph glands in the neck, armpit, or groin
- thoughts of hurting or killing oneself
- trouble sleeping
- unusual behavior
- unusual bleeding or bruising
- unusual tiredness or weakness
- weight gain
- yellowing of the eyes or skin

SEE YOUR PRIMARY CARE PROVIDER WHEN BEGINNING INTERFERON ALFA-2B THERAPY
And bring him or her this guide

Patients should be monitored closely with periodic clinical and laboratory evaluations by their PCP. Patients with persistently severe or worsening signs or symptoms of these conditions should be withdrawn from therapy. In many but not all cases, these disorders resolve after stopping interferon alfa-2b therapy.

The following laboratory tests are recommended for all patients on INTRON A therapy, prior to beginning treatment and then periodically thereafter:
• Mild-to-moderate leukopenia and elevated serum liver enzyme (AST, a.k.a. SGOT) levels have been reported with intralesional administration of INTRON A; therefore, the monitoring of these laboratory parameters should be considered paramount.
• Standard hematologic tests — including hemoglobin, complete and differential white blood cell counts, and platelet count.
• Blood chemistries — electrolytes, liver function tests, and TSH.
• Monitor hepatic function with serum bilirubin, ALT (alanine transaminase), AST (aspartate aminotransferase), alkaline phosphatase, and LDH (lactate dehydrogenase) at 2, 8 and 12 weeks following initiation of INTRON A, then every 6 months while receiving INTRON A.
• Baseline chest X-rays have been suggested and should be repeated if clinically indicated.
• Those patients who have preexisting cardiac abnormalities and/or are in advanced stages of cancer should have electrocardiograms taken prior to and during the course of treatment.
• Permanently discontinue INTRON A for evidence of severe (Grade 3) hepatic injury or hepatic decompensation (Child-Pugh score >6 [class B and C]).

- Serious eye problems. Interferon alfa-2b may cause eye problems that may lead to vision loss or blindness. You should have an eye exam before you start taking interferon alfa-2b. If you have eye problems or have had them in the past, you may need eye exams while taking interferon alfa-2b. Tell your healthcare provider or eye doctor right away if you have any vision changes while taking interferon alfa-2b.
- Thyroid problems. Some people develop changes in the function of their thyroid. Symptoms of thyroid problems include: problems concentrating, feeling cold or hot all the time, changes in your weight, skin changes
- Blood sugar problems. Some people may develop high blood sugar or diabetes. If you have high blood sugar or diabetes before starting interferon alfa-2b, talk to your healthcare provider before you take interferon alfa-2b.
- Mental health problems and suicide. Interferon alfa-2b may cause you to develop mood or behavior problems that may get worse during treatment.
- Infections. Some people who take interferon alfa-2b may get an infection.
- Heart problems. Some people who take interferon alfa-2b may develop heart problems, including, low blood pressure, fast heart rate or abnormal heart beats, trouble breathing or chest pain, heart attacks or heart muscle problems (cardiomyopathy).
- Stroke or symptoms of a stroke. Symptoms may include weakness, loss of coordination, and numbness. Stroke or symptoms of a stroke may happen in people who have some risk factors or no known risk factors for a stroke.
- New or worsening autoimmune disease. Some people taking interferon alfa-2b develop autoimmune diseases (a condition where the body's immune cells attack other cells or organs in the body), including rheumatoid arthritis, systemic lupus erythematosus, sarcoidosis, and psoriasis. In some people who already have an autoimmune disease, the disease may get worse while on interferon alfa-2b.
- You may need to have a chest X-ray or other tests if you develop fever, cough, shortness of breath, or other symptoms of a lung problem during treatment with interferon alfa-2b.

Contraindications: (continued)

Known Drug Interactions/Contraindications:

- telbivudine;
- theophylline; or
- zidovudine.

You should not use the combination of interferon alfa-2b and ribavirin if you have:

- severe kidney disease;
- a blood cell disorder such as thalassemia or sickle cell anemia;
- an allergy to interferons or ribavirin;
- if you are pregnant; or
- if you are a man and your sexual partner is pregnant.

Intron A INTERFERON ALFA-2b

Filing a claim with your insurance company for INTERFERON ALFA-2b

An acceptable indication recognized by most insurance companies for an INTERFERON ALFA-2b prescription is: “For the intralesional treatment of refractory or recurring external condylomata acuminate, ICD10 Diagnosis Code A63.0.”

- Ask your pharmacist to put through an insurance claim for your prescription of INTERFERON ALFA-2b, using the ICD10 diagnosis code A63.0
- If your pharmacist tries to process your prescription for interferon with your insurance company and your claim is denied, ask him or her for a written copy of the denial of your claim, before you leave the pharmacy.
- Sometimes, your insurance company will mail you a written denial of your claim, or you may have to contact them to obtain one.

If you must pay cash or credit for your medication, be sure to get a receipt.

- With a “written denial of your claim” and a “receipt”, our billing office can help you get your medical insurance company to pay your claim (unless of course INTERFERON ALFA-2b it is specifically excluded as a benefit under your policy).
- Please contact Arizona Computer Services Medical Billing (ACSMB) to help you file a claim for INTERFERON ALFA-2b with your insurance company. You will only need to provide ACSMB with a written denial of your claim and a receipt for the medication. Everything else ACSMB might need will be provided by your physician’s office.

  Arizona Computer Services Medical Billing
  77 E Columbus - Ste 214
  Phoenix, AZ 85012-2352
  Tel: +1 (602) 263-8958
  Fax: +1 (602) 277-5661
  Email: info@acsmb.com

OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Intron A® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name: Rick Shacket DO		
NPI#: 1215263850	Specialty: Proctology	
Office Phone: 602.492.9919		
Office Fax: drshacket@yahoo.com		
Office Street Address: 8752 E Via De Commercio #2		
City: Scottsdale	State: AZ	Zip: 85258

Medication Information (required)

Medication Name: INTRON A Solution for Injection	Strength: 10 MIU/mL	Dosage Form: 25 MIU
❑ Check if requesting **brand**	Directions for Use: Intralesional treatment of refractory condylomata	

Clinical Information (required)

Your patient's pharmacy benefit program is administered by UnitedHealthcare, which uses OptumRx for certain pharmacy benefit services. Your patient's benefit plan requires that we review certain requests for coverage with the prescribing physician. This includes requests for benefit coverage beyond plan specifications. Please complete the following questions and then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the benefit plan's rules.

Continuation of Therapy:*, ¥

Is this request for continuation of therapy? ❑ **Yes** ■ **No**

Will medical records be submitted documenting any of the information below? ❑ **Yes** ❑ **No**

Has the member been on the requested medication in the last 180 days or is currently stabilized? ❑ **Yes** ❑ **No**

Has the requested medication been safe and effective in treating the member's medical condition? ❑ **Yes** ❑ **No**

Has the member tried another prescription drug in the same pharmacological class or same mechanism of action? ❑ **Yes** ❑ **No**

Were prior medications discontinued due to a lack of efficacy or effectiveness, diminished effect, or an adverse event? ❑ **Yes** ❑ **No**

Select the diagnosis below:

- ❑ Chronic hepatitis B infection
- ❑ Chronic hepatitis C infection
- ❑ Adult T-cell leukemia/lymphoma
- ❑ AIDS-related Kaposi's sarcoma
- ☑ Condylomata acuminata (genital or perianal)
- ❑ Desmoid tumors/aggressive fibromatosis
- ❑ Follicular lymphoma
- ❑ Giant cell tumor of the bone
- ❑ Hairy cell leukemia
- ❑ Kidney cancer
- ❑ Leptomeningeal metastases
- ❑ Malignant melanoma
- ❑ Meningiomas
- ❑ Mycosis fungoides/ Sezary syndrome
- ❑ Myeloproliferative neoplasms (MPNs): Essential thrombocythemia (ET), polycythemia vera (PV), or primary myelofibrosis (PM)
- ❑ Other: _____ ICD-10 code(s): A63.0

Chronic Hepatitis B Infection:

Does the member have decompensated liver disease (defined as Child-Pugh Class B or C)? ❑ **Yes** ■ **No**

Chronic Hepatitis C Infection:

Does the member have decompensated liver disease (defined as Child-Pugh Class B or C)? ❑ **Yes** ■ **No**

Will Intron A be used as a part of a combination antiviral treatment regimen? ❑ **Yes** ■ **No**

Prescriber Attestation:

Does the prescriber attest that the information provided is true and accurate to the best of their knowledge and understand that United Healthcare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided? ❑ **Yes** ❑ **No**

Prescriber's signature: _____ Date: _____

*May not apply to all plans

¥Please note: Chart documentation of the above is required to be submitted along with this fax form

Intron A® Prior Authorization Request Form (Page 2 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review? Laser surgical ablation of condyloma lesions was tried on more than one occasion, and had failed. Furthermore, topical medications for condyloma are not approved for use inside body cavities.

Please note: **This request may be denied unless all required information is received within established timelines.**
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

CareFirst Family of health care plans

CVS caremark™

Intron A

Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-866-249-6155

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: Rick Shacket DO
Specialty: Proctology **NPI#:** 1215263850
Physician Office Telephone: 602.492.9919 **Physician Office Fax:** drshacket@yahoo.com
Request Initiated For: _____

1. What is the diagnosis?
   - ❑ Hepatitis B virus (including Hepatitis D co-infection)
   - ❑ Hepatitis C virus
   - ☑ Condylomata acuminata
   - ❑ Chronic myelogenous leukemia (CML)
   - ❑ Malignant melanoma
   - ❑ Renal cell carcinoma (RCC)
   - ❑ Clinically aggressive follicular non-Hodgkin's lymphoma
   - ❑ Giant cell tumor of the bone
   - ❑ Other _____
   - ❑ Systemic light chain amyloidosis
   - ❑ Desmoid tumors
   - ❑ Adult T-cell leukemia/lymphoma (ATLL)
   - ❑ Hairy cell leukemia
   - ❑ AIDS-related Kaposi's Sarcoma
   - ❑ Mycosis fungoides/Sézary syndrome
   - ❑ Polycythemia Vera
2. What is the ICD-10 code? A63.0

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Condylomata Acuminata

3. Is the patient a candidate for standard treatment options (e.g., Podofilox, Imiquimod, Cryotherapy, Podophyllin resin)? ❑ Yes ☑ No * Because topical medications for condyloma are not approved for use inside body cavities.

Section B: Chronic Myelogenous Leukemia

4. Is the patient unable to tolerate kinase inhibitor(s) or is post-hematopoietic stem cell transplant? ❑ Yes ❑ No

Section C: Hepatitis B or C Virus

5. How many weeks of current course of drug therapy has the patient received? _____weeks

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

04/25/2016

Prior Authorization

AETNA BETTER HEALTH OF LA MEDICAID

Intron A (LA88)

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 of Louisiana at **1-844-699-2889**.
Please contact Aetna Better Health of Louisiana at **1-855-242-0802** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Intron A (LA88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Intron-A Powder for Soln (interferon alfa-2B) Intron-A Soln for Injection (interferon alfa-2B)

Quantity 25 MIU Frequency 1 to 5 MIU 2 or 3x weekly Strength 10 MIU/mL

Route of Administration Intralesional Expected Length of therapy 30 days

Patient Information

Patient Name:

Patient ID:

Patient Group No.:

Patient DOB:

Patient Phone:

Prescribing Physician

Physician Name: Rick Shacket DO

Specialty: Proctology NPI Number: 1215263850

Physician Fax: drshacket@yahoo.com Physician Phone: 602.492.9919

Physician Address: 8752 E Via de Commercio #2 City, State, Zip: Scottsdale, AZ 85258

Diagnosis: AnoGenital Warts Due to HPV ICD Code: A63.0

Please circle the appropriate answer for each question.

1. Has this plan authorized Intron A in the past for this patient (i.e., previous authorization is on file under this plan)? ☐ ☐

   [If yes, skip to question 22.]

2. Is Intron A prescribed by, or in consultation with an appropriate specialist based on the condition being treated: List specialty: ✔ N

   Proctology

   [If no, then no further questions.]

3. Does the patient have a diagnosis of chronic hepatitis B? Y ✔

   [If no, skip to question 10.]

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

   [If no, skip to question 6.]

5. Does the patient have HBeAg titers and/or hepatitis B DNA levels greater than 20,000 IU/mL? Y N

   [If no, then no further questions.]

   [If yes, skip to question 7.]

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

   [If no, then no further questions.]

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

   [If no, then no further questions.]

8. Is there evidence of liver inflammation (e.g., elevated ALT, inflammation or fibrosis on liver biopsy)? Y N

   [If no, then no further questions.]

9. Is the patient at least 1 year old? Y N

   [No further questions.]

10. Does the patient have a diagnosis of AIDS-related Kaposi's sarcoma? Y ✔N

    [If no, skip to question 13.]

11. 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.]

12. Is the request for the powder for solution formulation? Y N

    [If no, then no further questions.]

    [If yes, skip to question 21.]

13. Does the patient have a diagnosis of hairy cell leukemia? Y ✔N

    [If no, skip to question 16.]

14. Does the patient meet ONE of the following criteria: Had an incomplete response to cladribine or pentostatin \ Had disease relapse within 1 year after responding to cladribine or pentostatin. — Y N

[If no, then no further questions.]

15. Does the patient have at least ONE of the following: Systemic symptoms fatigue, weakness, weight loss, fever, night sweats \ Symptomatic splenomegaly or adenopathy \ Significant cytopenias hemoglobin less than 12 g/dL, platelet count less than 100,000/mcL, or ANC less than 1000/mcL — Y N

[If no, then no further questions.]

[If yes, skip to question 21.]

16. Does the patient have a diagnosis of malignant melanoma? — Y ✔

[If no, skip to question 18.]

17. 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 21.]

18. Does the patient have a diagnosis of Condylomata acuminate (genital warts)? — ✔ N

[If no, then no further questions.]

19. Has the patient failed at least 2 other standard treatments for the same lesion [e.g., cryotherapy, laser removal, surgical excision, electrodessication, imiquimod (Aldara) cream, Condylox]: If yes, list treatments tried and dates: — ✔ N

Laser removal on: / / & / / , or Imiquimod 5% cream on: / / .

[If no, then no further questions.]

20. Are the lesion(s) small in size and limited in number and Intron A is prescribed for intralesional use? — ✔ N

[If no, then no further questions.]

21. Is the patient at least 18 years old? — ✔ N

[No further questions.]

22. Is Intron A prescribed to treat hepatitis B? Y ☑

[If no, skip to question 25.]

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

[If yes, then no further questions.]

24. Has the patient already received 2 years of treatment with Intron A? ☐ ☐

[No further questions.]

25. Is the patient responding to treatment with Intron A? ☐ ☐

Comments:

Laser surgical ablation of condyloma lesions was tried on more than one occasion, and had failed. Furthermore, topical medications for condyloma are not approved for use inside body cavities.

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

Prescriber (Or Authorized) Signature Date

BlueCross BlueShield Federal Employee Program

INTRON-A
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form.

Member Information (required)			**Provider Information (required)**		
Date:			Provider Name: Rick Shacket DO		
Cardholder Name:			Specialty: Proctology	NPI: 1215263850	
Member Name:			Office Phone: 602.920.1023		
Date of Birth:	Sex: Male Female		Office Fax: drshacket@yahoo.com		
Street Address:			Office Street Address: 8752 E Via de Commercio #2		
City:	State:	Zip:	City: Scottsdale	State: AZ	Zip: 85258
Cardholder ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

Intron A (interferon alfa-2b)

NOTE: Form must be completed in its **entirety** for processing

1. What is the treatment for which Intron A is being used?

❒ Hepatitis B

a. Is the patient's diagnosis of hepatitis B a chronic condition? ❒Yes ❒No

b. Does the patient have compensated liver disease? ❒Yes ❒No

c. Has the patient been hepatitis B surface antigen (HBsAG) positive for at least 6 months? ❒Yes ❒No

d. Is there current evidence of hepatitis B replication via either a positive hepatitis B e antigen (HBeAG) or a positive hepatitis B viral DNA level? ❒Yes ❒No

e. Is the patient's serum alanine aminotransferase (ALT) at least twice the upper limit? ❒Yes ❒No

f. Is the patient an immunosuppressed transplant recipient? ❒Yes ❒No

❒ Hepatitis C

a. Does the patient have compensated liver disease? ❒Yes ❒No

b. Is the patient an appropriate candidate for treatment with a pegylated interferon in combination with ribavirin and a protease inhibitor (such as: Victrelis, Incivek, or Olysio)? ❒Yes ❒No

c. Is the patient an immunosuppressed transplant recipient? ❒Yes ❒No

d. Will the patient be using Intron A in combination with Ribavirin? ***Please select answer below:***

❒ **YES - Combination therapy with Ribavirin,** please answer the following questions:

i. Is the patient's diagnosis of hepatitis C a chronic condition? ❒Yes ❒No

ii. Has the patient been previously treated with alpha interferon? ❒Yes* ❒No

***If YES**, has the patient relapsed following alpha interferon therapy? ❒Yes ❒No

iii. Is the patient or the patient's partner pregnant? ❒Yes ❒No*

***If NO**, have the patient or the patient's partner have been or will be instructed to practice effective contraception during therapy and for 6 months after stopping ribavirin therapy? ❒Yes ❒No ❒Not of child-bearing age

iv. Has the patient been diagnosed with renal failure? ❒Yes ❒No

❒ **NO – Monotherapy *(Intron A only)*,** please answer the following questions:

i. Has the patient's chronic hepatitis C been confirmed by liver biopsy? ❒Yes ❒No

ii. Does the patient have a history of blood or blood product exposure? ❒Yes ❒No

iii. Has the patient tested positive for antibodies to hepatitis C? ❒Yes ❒No

iv. Does the patient have significant intolerance or contraindication to ribavirin? ❒Yes ❒No

***Examples include hemoglobin level below 8.5 g/dL, a hemoglobinopathy such as thalassemia major or sickle-cell anemia**

v. **FEMALE patient**: Is the patient pregnant? ❒Yes ❒No

vi. Does the patient have a history of unstable heart disease? ❒Yes ❒No

❒AIDS-related Kaposi's sarcoma ❒Carcinoid tumor ☑Condylomata acuminate ❒Follicular lymphoma
❒Hairy cell leukemia ❒Malignant melanoma ❒Polycythemia vera ❒Renal cell cancer
❒Cutaneous T-cell lymphoma (Mycosis Fungoides and Sezary Syndrome)

❒Other diagnosis ***(please specify):*** _____

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Intron-A – FEP CSU_MD Fax Form Revised 8/3/2018

BlueCross BlueShield
Federal Employee Program

INTRON-A
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug prior authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same info contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727** Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the PA request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***