



PEGYLATED INTERFERON SUMMARY

PREFERRED	Pegasys/Proclick (peginterferon alfa-2a), Sylatron (peginterferon alfa-2b)
NON-PREFERRED	Peg-Intron/Redipen (peginterferon alfa-2b)

LENGTH OF AUTHORIZATION: 1 year (365 days) for diagnosis of carcinoma; 48 weeks (336 days) for diagnoses of hepatitis B; length of authorization for hepatitis C varies based on genotype, co-infection with HIV, CD4 counts and HCV-RNA viral titers

PA CRITERIA:

For Pegasys

- ❖ Approvable for members with a diagnosis of Hepatitis B
- OR*
- ❖ Approvable for members with a diagnosis of carcinoma
- OR*
- ❖ Approvable for members with a diagnosis of Hepatitis C; Physician should submit faxed documentation of viral titer.

For Peg-Intron

- ❖ Approvable for members with a diagnosis of Hepatitis C; Physician should submit faxed documentation of viral titer.
- ❖ Physician should submit documentation of allergies, contraindications, drug-drug interactions, or a history of intolerable side effects to Pegasys.

For Sylatron

- ❖ Approvable for members with a diagnosis of melanoma with microscopic or gross nodal involvement (Stage III melanoma) when prescribed within 84 days of definitive surgical resection, including complete lymphadenectomy

EXCEPTIONS:

- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process.
- ❖ The Prior Authorization process may be initiated by calling **Catamaran at 1-866-525-5827.**

PA and APPEAL PROCESS:

- ❖ For online access to the PA process please go to www.mmis.georgia.gov/portal, highlight the pharmacy link on the top right side of the page, and click on “prior approval process”.

QUANTITY LEVEL LIMITATIONS:

- ❖ For online access to the current Quantity Level Limit please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services Part II and select that manual.