

Date/Time of Request: Date: _____ Time: _____

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of Alferon-N[®](interferon alpha n-3). Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. – Member Information:

Patient Name:		Plan Name:	
Patient ID:	Patient Date of Birth:	Patient Contact Phone#:	

B. – Physician Information

Physician Name:		Physician Address:	
Physician DEA #:		Physician Phone #:	Physician Fax Number:
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC#:

C. – Pharmacy Information

Pharmacy Name:	NABP #:	Pharmacy Phone Number:	Pharmacy Fax Number:
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D. – Clinical Information: Please fill out the following clinical information: (circle all that apply)

1. Is patient at least 18 years of age? YES NO
2. Does patient have refractory recurring Condylomata acuminata? YES NO
3. Has patient tried and failed any of the following therapy modalities? YES NO
 - podophyllin resin
 - surgery
 - laser
 - cryotherapy

Authorized Medical Signature:			
Telephone:		Date:	

When Completed Return To: ProCare PBM Clinical Division 3090 Premiere Parkway Ste 100 Duluth, GA 30097
1-866-965-Drug (3784)/ Fax # 866-999-7736

Receipt Date/Time of Completed Request: _____		<u>FOR INTERNAL USE ONLY</u>		Ticket Number: _____	
<input type="checkbox"/> Approved	<input type="checkbox"/> Denied	(Date/Time)			
Reviewed by: _____	Effective Date: _____	Member Contacted: _____			
Review Date: _____	Termination Date: _____	MD Contacted: _____			
Review Time: _____		Pharmacy Contacted: _____			