

# Drug Coverage Review Request

## Alferon N<sup>®</sup>

35045



### SUPPLY ALL PRESCRIBER AND PATIENT INFORMATION

#### PRESCRIBER

MD First Name \_\_\_\_\_  
MD Last Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_  
DEA number (optional) \_\_\_\_\_

#### PATIENT

Cardholder's ID# \_\_\_\_\_  
Patient Last Name \_\_\_\_\_  
Patient First Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_

### SECTION A Answer the following questions

1. Specify the NAME and STRENGTH of the prescribed medication: \_\_\_\_\_
2.  Yes  No Is Interferon Alpha-n3 (for example, *Alferon N*) being prescribed for the treatment of condyloma acuminata (genital warts)?
3.  Yes  No If YES to the previous question, has conventional therapy failed to treat this patient's condyloma acuminata?

### SECTION B Physician Signature

\_\_\_\_\_  
PHYSICIAN SIGNATURE

\_\_\_\_\_  
DATE

**FAX COMPLETED FORM TO: 1 800 837-0959**

PLEASE DO NOT FAX WITH A COVER SHEET

Location: Nevada (15) Case Id: 9999999



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