Prior Authorization Guideline

Guideline Name	Peginterferon alfa-2a

Guideline Note:

Effective Date:	10/1/2026

1 . Chronic Hepatitis D Criteria

Product Name: Peginterferon alfa-2a	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic hepatitis D infection

AND

2 - Prescribed by or in consultation with one of the following:
2.1 Gastroenterologist

OR

2.2 Hepatologist

OR

2.3 Infectious disease specialist

AND

3 - Patient is 18 years of age or older

AND

4 - Medical record documentation showing detectable serum HDV RNA levels within the last 6 months

Product Name: Peginterferon alfa-2a	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria
1 - Medical record documentation of one of the following:
1.1 Reduction in HDV RNA levels

OR

1.2 Reduction or normalization of ALT lab values from baseline

2 . Criteria for Other Uses

Product Name: Peginterferon alfa-2a	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria
1 - Peginterferon alfa-2a is being used for one of the following:
1.1 Chronic hepatitis B

OR

1.2 Chronic hepatitis C

OR

1.3 Essential thrombocythemia

OR

1.4 HIV/hepatitis B co-infection

OR

1.5 Polycythemia vera

Product Name: Peginterferon alfa-2a	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Medical record documentation showing clinical response to therapy	