



**SAN FRANCISCO
HEALTH PLAN™**

Here for you

201 Third Street, 7th Floor • San Francisco, CA 94103
(415) 547-7800 • FAX (415) 547-7821 • www.sfhp.org

Dear Provider and Clinic Staff,
San Francisco Health Plan (SFHP) has evidence-based guidelines in place to ensure your patients are optimally treated for Hepatitis B¹. As you know, medications used to treat Hepatitis B have a high rate of resistance and therefore treatment failure. To prevent this, we require laboratory monitoring every 6 months to assess for adequate response to therapy.

When submitting a prior authorization (PA) request for *Baraclude*[®], *Epivir HBV*[®], *Hepsera*[®], *Tyzeka*[®], *Truvada*[®], and *Viread*[®], please make sure:

- Use the specific PA form for Hepatitis B medications
Form is available at http://www.sfhp.org/providers/provider_resources/
- Requested duration is a maximum of 6 months
- Attach lab results for HBV DNA, HBV serology (HBsAg, HBeAb, HBeAg) and liver function tests obtained within previous 30 days of request date

Any requests missing the above parameters will be sent back for more information. Completion of all required fields on the PA form will help SFHP determine compliance with the evidence-based guidelines.

Thank you,
Pharmacy Department
San Francisco Health Plan

1. <http://www.annals.org/content/150/2/104.full.pdf+html>



Prescriber Information

Last Name: <input type="text"/> DEA/NPI: <input type="text"/> Phone: <input type="text"/>	First Name: <input type="text"/> Specialty: <input type="text"/> Fax: <input type="text"/>
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Pharmacy Information

Pharmacy Name: <input type="text"/>	Fax: <input type="text"/>
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Member Information

Last Name: <input type="text"/> Member ID Number: <input type="text"/>	First Name: <input type="text"/> DOB: <input type="text"/>
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Medication Information:

<input type="checkbox"/> Baraclude <input type="checkbox"/> 0.5mg <input type="checkbox"/> 1mg <input type="checkbox"/> 0.05mg/ml	<input type="checkbox"/> Epivir HBV <input type="checkbox"/> 100mg <input type="checkbox"/> 5mg/ml	<input type="checkbox"/> Hepsera 10mg	<input type="checkbox"/> Tyzeka 600mg	<input type="checkbox"/> Truvada	<input type="checkbox"/> Viread 300mg
Diagnosis (check one): <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Pre-core mutant Hepatitis B		Daily dosage instructions: <i>Requests are limited to 30 days supply for maximum 6 months duration.</i>			

Hepatitis B Prior Authorization Criteria

Please address ALL of the following criteria:		
1. Attach lab results for HBV DNA, HBV serology (HBsAg, HBeAb, and HB) and liver function test. Lab must be drawn within 30 days of request date.		
2. Is the member therapy naïve?	Y	N
3. Is the member currently receiving the requested medication?	Y	N
4. If no, is this member receiving another Hepatitis B medication?	Y	N
5. If yes, list the medication:		

Information given on this form is accurate as of this date.

Prescriber or Authorized Signature

Date _____

I understand that Informed Rx's use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).