



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"/>
---	--

Pharmacy Information

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

Member Information

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

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).