pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

HEPATITIS B AGENTS PRIOR AUTHORIZATION FORM

- **Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request.**
- To review the prior authorization guidelines for Hepatitis B Agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Hepatitis B Agents** (accessible at: http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm).
- These agents are also subject to quantity limits. If the requested quantity exceeds the limit, please submit supporting chart documentation (refer to Quantity Limits list at: http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm).

PRIOR AUTHORIZATION INFORMATION		**PRESCRIBER INFORMATION**	
☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:
☐adefovir tablet ☐Epivir HBV tablet ☐Vemlidy tablet
☐Baraclude tablet ☐tenofovir disoproxil fumarate tablet ☐_____

Strength:	Dose/directions:	Quantity:	Refills:

Diagnosis *(submit documentation)*: | Dx code (*required*):

1. Hepatitis B Agents are part of the Department's Specialty Pharmacy Drug Program (SPDP) (with the exception of TDF & Viread). Which specialty pharmacy will be used?
   ☐Diplomat Specialty Pharmacy
   ☐Walgreens Specialty Pharmacy

2. Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred Hepatitis B Agents? *Check all that apply.*
   ☐Baraclude solution ☐Hepsera tablet
   ☐entecavir tablet ☐lamivudine HBV tablet
   ☐Epivir HBV solution ☐Viread tablet or powder

   ☐Yes – *Submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances.*
   ☐No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: