

Fax completed form to: 1-866-868-0858  
Questions, please call: 1-866-316-6049

**Important Information About Prescription Drug Coverage**

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To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

Re: Hepsera® (adefovir ): Prior Authorization Request Form: Please respond.

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- Please complete the attached Hepsera® (adefovir ) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

**Please note:** By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

**Information about this drug**

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**Hepsera® (adefovir )**

Hepsera® should be limited to patients who have failed a prior trial of lamivudine or telbivudine therapy. The use of Hepsera® is limited by a slow onset of viral suppression. Up to 25 percent of patients treated with Hepsera® experience minimal or no viral suppression.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

**Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.**

# Prior Authorization Request Form

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## Patient Information

Name \_\_\_\_\_  
Member ID \_\_\_\_\_  
Medicare ID \_\_\_\_\_  
Date of birth \_\_\_\_\_ Sex: M / F  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_  
Nursing home resident? YES / NO  
Home care patient? YES / NO

## Prescriber and Pharmacy Information

Name \_\_\_\_\_  
Specialty \_\_\_\_\_  
DEA \_\_\_\_\_  
NPI \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Pharmacy name \_\_\_\_\_  
NCPDP \_\_\_\_\_  
NPI \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

## All items below this line are for Physician Use Only

### Information for Requested Drug

Strength: \_\_\_\_\_ Dosage form: \_\_\_\_\_ Qty per 30 days: \_\_\_\_\_ Drug is (circle one): Newly prescribed/Refill  
Directions: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

### Hepsera® (adefovir ) Criteria

- 1 Please indicate the patient's diagnosis. Select or specify the correct ICD-9 code. **This question must be completed.**  
 Chronic hepatitis B (ICD-9: 702.2, 702.3, 703.2, 703.3) in adults with evidence of active viral replication and either evidence of persistent elevations in serum aminotransferases (ALT or AST) or histologically active disease?  
 Other (diagnosis and ICD-9 code): \_\_\_\_\_  
monitored closely for renal function and may require dose adjustment.
- 2 Is the prescribing physician a gastroenterologist or has a gastroenterologist been consulted?  
 Yes  No
- 3 Does the patient have any contraindications to the use of Hepsera® (e.g., hypersensitivity)?  
 Yes  No
- 4 Has the patient failed to receive a clinically appropriate therapeutic response OR demonstrated intolerance (e.g., allergy, hypersensitivity, adverse effects, development of a contraindication) from lamivudine or telbivudine over a period of 30 days or more?  
 Yes  No  
 In patients at risk of or having underlying renal dysfunction, chronic administration of adefovir dipivoxil may result in nephrotoxicity. These patients should be

Medical justification: (Attach additional page if necessary): \_\_\_\_\_

Prescriber's signature: \_\_\_\_\_ Date: \_\_\_\_\_