

Date of Request: \_\_\_\_\_

## Sterling Retiree Rx Prior Authorization Form

### HEPSERA (Adefovir Dipivoxil)

**Prescriber must be Gastroenterologist or Infectious Disease**

#### Coverage Criteria / Required Medical Information

**Age Restriction: patient is at least 12 years of age**

- A. The patient has been diagnosed with chronic hepatitis B.
- B. AND the patient has evidence of a positive HBsAg (+ or -) serological marker for > 6 months **or** evidence by a liver biopsy showing chronic hepatitis.
- C. AND the patient has a Hepatitis B viral load > 20,000 IU/ml (100,000 copies per ml).
- D. AND the patient has elevations in liver aminotransferases (ALT or AST) that are two (2) times greater than normal **or** normal liver aminotransferase (ALT or AST) levels with evidence of significant disease found on biopsy.
- E. AND the patient has been tested for HIV. (Hepsera therapy can cause HIV resistance in untreated HIV infection).
- F. AND the patient is not receiving duplicate therapy that includes Baraclude, Tyzeka, and/or Intron A.
- G. AND documented evidence of diagnosis, serological markers or liver biopsy, viral load and liver aminotransferases.
- H. If the patient has received previous Hepsera treatment, there is documented clinical improvement shown by a drop in viral load or reduction in the patient's liver aminotransferases.

#### Exclusion Criteria:

Renal impairment without dosing adjustment, if the patient is taking/receiving tenofovir or PMPA.

#### Member Information

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

#### Physicians Information

Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			



**Sterling Retiree Rx Prior Authorization Form**

Requested Drug			
HEPSERA	Reason for Request		
Condition/Diagnosis Related			
Clinical Drug/Lab History Pertinent to Request			
Labs: Baseline/Ongoing		Strength/Dosage	
Formulary Alternative(s) Attempted?		Yes:	No:
Please List Alternative Formulary Drugs			
Comments			

Physicians Signature: \_\_\_\_\_

Fax Form to 1-866-481-3704