



**PRIOR AUTHORIZATION REQUEST FORM**

**EOC ID:**

**Baraclude® (Entecavir)**

**Phone: 215-991-4300 Fax back to: 866-240-3712**

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please print clearly.**

<b>Patient Name:</b>	<b>Physician Name:</b>
Member Number:	Fax: <span style="float: right;">Phone:</span>
Date of Birth:	Office Contact:
Group Number:	NPI: <span style="float: right;">State Lic. Id:</span>
Address:	Address:
City, State, Zip:	City, State, Zip:

Drug Name: Expedited/Urgent

Directions:

<b>Please answer the following questions and sign below:</b>
Q1. What is the requested duration of therapy? 6 months or less Greater than 6 months
Q2. Has the patient been diagnosed with chronic Hepatitis B virus infection? Yes No
Q3. Does the patient have detectable viral replication (detectable serum HBV DNA)? If YES, please provide documentation. Yes No
Q4. Does the patient have active inflammation as evidenced by elevated ALT levels greater than 2 times the upper limit of normal? If YES, please provide documentation. Yes No
Q5. Does the patient have Cirrhosis or are moderate to severe inflammatory changes evident on liver biopsy? If YES, please provide documentation. Yes No

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**Physician Signature**

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**Date**