

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

HEPSERA (adeforvir dipivoxil)

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**DOCUMENTATION FROM PROGRESS NOTES OR LETTER OF
MEDICAL NECESSITY TO 855-828-4992 note the new fax number**

CRITERIA:

- Diagnosis of hepatitis B
- Failure on Epivir

INFORMATION:

10mg/day max dose.

AUTHORIZATION:

Initial prior is for 12 weeks.

RE-AUTHORIZATION:

12 months with updated letter of medical necessity

9/13/10

<http://health.utah.gov/medicaid/pharmacy>