PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Commercial (Traditional)** ☐ **Commercial (Individual/Optimized)** ☒ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Vemlidy® (tenofovir alafenamide)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Vemlidy 25 mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Must have a diagnosis of Chronic Hepatitis B infection with compensated liver disease
2. Must be tested for and is HIV negative (if positive must provider further justification for use due to HIV treatment resistance risk)
3. Failure of Entecavir, at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced
4. Use not recommended in those in those with CrCl < 15 mL/minute or if Child-Pugh class B or C

For continuation, patient must have met the following requirements:

1. HBV DNA testing every three months until undetectable for at least two consecutive visits then decreased to every six months.
2. Aminotransferases testing every three to six months.
3. Creatinine and phosphate testing every 6 months.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Additional information

Note: Initial approval length 6 months, with requests for continuation required every 6 months thereafter.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 02/2018

Last reviewed 11/2019

PriorityHealth

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Chronic Hepatitis B infection with compensated liver disease
- ☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. Has the patient been tested for and is HIV negative?

- ☐ HIV negative
- ☐ HIV positive, *rationale for use*: _____
- ☐ Has not been tested, *rationale*: _____

C. Has the patient had a failure on Entecavir, up to maximally indicated doses (please provide dose and dates of use)?

- ☐ Yes, Dose: _____ Dates of use: _____
- ☐ No, *rationale:* _____

D. What is the patient's creatinine clearance? _____

E. What is the patients Child-Pugh class? _____

Request for Continuation
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Chronic Hepatitis B infection with compensated liver disease
- ☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. Does patient meet monitoring criteria listed under criteria? Please describe.

- ☐ Yes, *dates of labs (or attach to request)*: _____
- ☐ No, *rationale*: _____

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