maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Vemlidy

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Will the patient be taking the requested medication in combination with tenofovir disoproxil fumarate or entecavir? [If yes, no further questions.]	Yes	No
2	Is the patient currently receiving the requested medication? [If no, skip to question 14.]	Yes	No
3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 14.]	Yes	No
4	Does the patient have a previously approved PA on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the	Yes	No

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1-888-258-8250

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	requested medication with the current plan, the renewal request will be considered under initial therapy.] [If yes, skip to question 6.]		
5	Has documentation been submitted to confirm that the patient has had a clinical response to therapy, compared to baseline? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 14.] [If no, no further questions.]	Yes	No
6	What is the indication or diagnosis? [] Hepatitis B Virus (HBV) (If checked, go to 7) [] HIV-1 Infection/HBV Co-Infection Treatment (If checked, go to 11) [] Other (If checked, no further questions)		
7	Has the patient been on the established therapy for at least 90 days? [If no, skip to question 15.]	Yes	No
8	Is the requested medication being prescribed by or in consultation with an infectious disease specialist, gastroenterologist or hepatologist? [If no, no further questions.]	Yes	No
9	Has documentation been submitted to confirm that the patient has had a clinical response to therapy compared to baseline, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	Has laboratory tests been obtained within 60 days of renewal showing that the patient continues to be HIV-1 negative? [No further questions.]	Yes	No
11	Has the patient been on the established therapy for at least 90 days? [If no, skip to question 26.]	Yes	No
12	Is the requested medication being prescribed by or in consultation with an infectious disease specialist, gastroenterologist or hepatologist? [If no, no further questions.]	Yes	No
13	Has documentation been submitted to confirm that the patient has had a clinical response to therapy compared to baseline, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
14	What is the indication or diagnosis? [] Hepatitis B Virus (HBV) (If checked, go to 15)		

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	[] HIV-1 Infection/HBV Co-Infection Treatment (If checked, go to 26)		
	[] Other (If checked, no further questions)		
15	Is the patient greater than or equal to 12 years of age? [If no, no further questions.]	Yes	No
16	Does the patient have a diagnosis of chronic hepatitis B infection? [If no, no further questions.]	Yes	No
17	Has documentation been submitted to confirm that the patient has compensated liver disease as evidenced by ALL of the following: A) No evidence of ascites, B) Hepatic encephalopathy or variceal bleeding, C) INR less than 1.5 x ULN, D) Total bilirubin less than 2.5 x ULN AND E) Albumin greater than 3.0 g/dL? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
18	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or treatment failure with tenofovir disoproxil fumarate and entecavir? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
19	Is the patient intolerant to tenofovir disoproxil fumarate due to a diagnosis of osteoporosis/osteopenia? [If no, skip to question 21.]	Yes	No
20	Has documentation been submitted to confirm that the patient has a diagnosis of osteoporosis/osteopenia as defined by: Osteoporosis: bone mineral density (BMD) T-score less than or equal to 2.5 and Osteopenia: bone mineral density (BMD) T-score between -1 and -2.5? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 23.] [If no, no further questions.]	Yes	No
21	Does the patient have an intolerance, contraindication or treatment failure with tenofovir disoproxil fumarate and entecavir due to worsening renal function? [If no, skip to question 23.]	Yes	No
22	Has documentation been submitted to confirm that the patient has an intolerance, contraindication or treatment failure to tenofovir disoproxil fumarate and entecavir due to worsening of renal function as evidenced by changes in CrCl (creatinine clearance) labs from baseline? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
23	Is the requested medication being prescribed by or in consultation with an infectious disease specialist, gastroenterologist or hepatologist? [If no, no further questions.]	Yes	No

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24	Does the requested dose exceed the FDA approved label dosing for the indication? [If yes, no further questions.]	Yes	No
25	Has the patient tested negative for HIV-1 within the last 60 days? [No further questions.]	Yes	No
26	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or treatment failure with emtricitabine and tenofovir disoproxil fumarate (Truvada) and/or Bictegravir, emtricitabine, and tenofovir alafenamide (Biktarvy)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
27	Is the patient intolerant to tenofovir disoproxil fumarate due to a diagnosis of osteoporosis/osteopenia? [If no, skip to question 29.]	Yes	No
28	Has documentation been submitted to confirm that the patient has a diagnosis of osteoporosis/osteopenia as defined by: Osteoporosis: bone mineral density (BMD) T-score less than 2.5 and Osteopenia: bone mineral density (BMD) T-score between -1 and -2.5? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 31.] [If no, no further questions.]	Yes	No
29	Does the patient have an intolerance, contraindication or treatment failure with emtricitabine and tenofovir disoproxil fumarate (Truvada) and/or Bictegravir, emtricitabine, and tenofovir alafenamide (Biktarvy) due to worsening renal function? [If no, skip to question 31.]	Yes	No
30	Has documentation been submitted to confirm that the patient has an intolerance, contraindication or treatment failure to emtricitabine and tenofovir disoproxil fumarate (Truvada) and/or Bictegravir, emtricitabine, and tenofovir alafenamide (Biktarvy) due to worsening of renal function as evidenced by changes in CrCl (creatinine clearance) labs from baseline? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
31	Is the requested medication being prescribed by or in consultation with an infectious disease specialist, gastroenterologist or hepatologist? [If no, no further questions.]	Yes	No
32	Does the requested dose exceed the FDA approved label dosing for the indication?	Yes	No

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Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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