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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is this request for initial therapy or for a continuation of therapy? [] Initial (If checked, go to 10) [] Continuation (If checked, go to 2)		
2	Will the patient be taking the requested medication in combination with tenofovir disoproxil fumarate or entecavir? [If yes, no further questions.]	Yes	No

If you have any questions, call:
1-888-258-8250

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3	Is the patient currently receiving the requested medication? [If no, skip to question 10.]	Yes	No
4	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 10.]	Yes	No
5	Does the patient have a previously approved prior authorization (PA) on file with the current plan for the requested medication? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 10.]	Yes	No
6	Has the patient been established on therapy for at least 3 months? [If no, skip to question 10.]	Yes	No
7	What is the indication or diagnosis? [] Hepatitis B virus (HBV) (If checked, go to 8) [] Human immunodeficiency virus (HIV)-1 Infection/hepatitis B virus (HBV) co-infection treatment (If checked, go to 9) [] Other (If checked, no further questions)		
8	Have laboratory tests been obtained within 60 days of renewal showing that the patient continues to be human immunodeficiency virus (HIV)-1 negative? [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? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
10	Will the patient be taking the requested medication in combination with tenofovir disoproxil fumarate or entecavir? [If yes, no further questions.]	Yes	No
11	What is the indication or diagnosis? [] Hepatitis B Virus (HBV) (If checked, go to 12) [] Human immunodeficiency virus (HIV)-1 Infection/hepatitis B virus (HBV) co-infection treatment (If checked, go to 23) [] Other (If checked, no further questions)		

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12	Is the patient greater than or equal to 6 years of age and weighs 25 kg or greater? [If no, no further questions.]	Yes	No
13	Does the patient have a diagnosis of chronic hepatitis B infection? [If no, no further questions.]	Yes	No
14	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) International normalized ratio (INR) less than 1.5 x upper limit of normal (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
15	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
16	Is the patient intolerant to tenofovir disoproxil fumarate due to a diagnosis of osteoporosis/osteopenia? [If no, skip to question 18.]	Yes	No
17	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 20.] [If no, no further questions.]	Yes	No
18	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 20.]	Yes	No
19	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 creatinine clearance (CrCl) labs from baseline? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
20	Has the patient tested negative for human immunodeficiency virus (HIV)-1 within the last 60 days? [If no, no further questions.]	Yes	No
21	Is the requested medication being prescribed by or in consultation with an infectious disease specialist, gastroenterologist or hepatologist?	Yes	No

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	[If no, no further questions.]		
22	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [No further questions.] [Note: Dosing is 25 mg once daily.]	Yes	No
23	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
24	Is the patient intolerant to tenofovir disoproxil fumarate due to a diagnosis of osteoporosis/osteopenia? [If no, skip to question 26.]	Yes	No
25	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 27.] [If no, no further questions.]	Yes	No
26	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 as evidenced by changes in creatinine clearance (CrCl) labs from baseline? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
27	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
28	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing is 25 mg once daily.]	Yes	No

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

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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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