

**Blue Cross Blue Shield of Vermont and The Vermont Health Plan  
Prior Approval Form  
Baraclude® (entecavir)  
BCBSVT and TVHP Fax # (888)-255-1006**

If approval criteria are met Blue Cross and Blue Shield of Vermont will authorize coverage of Baraclude® (Entecavir) Tablets. Thank you for your assistance.

**PLEASE COMPLETE THE FOLLOWING SECTIONS:**

Date of Request \_\_\_\_\_ Patient Name: \_\_\_\_\_  
 BCBSVT/TVHP Member ID#: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 Provider Name: \_\_\_\_\_ Provider Phone number: \_\_\_\_\_  
 Provider Fax number: \_\_\_\_\_ PCP Name: \_\_\_\_\_

**INDICATIONS FOR USE:**

	<u>YES</u>	<u>NO</u>
1. Patient is an adult diagnosed of chronic hepatitis B with evidence of active viral replication and either evidence of persistent elevations in serum aminotransferases (transaminases) ALT/ AST (>2 fold) or histologically active disease.	<input type="checkbox"/>	<input type="checkbox"/>
2. If this request is new or a renewal of a previous approval, please indicate if the patient's most recent serology result is positive or negative by circling at the right and indicating the date of test and results below: <b>Date of labwork:</b> _____ <b>HBsAg:</b> _____ <b>HBeAg:</b> _____ <b>ALT/AST Level:</b> _____ <b>HBeAb:</b> _____ <b>HBV-DNA:</b> _____	Circle one for each <b>HBsAg: (+) (-)</b> <b>HBeAg: (+) (-)</b> <b>HBeAb: (+) (-)</b> <b>HBV-DNA:(+) (-)</b>	
3. Has the persistence of HBsAg been for longer than 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
4. Prescriber is a Gastroenterologist, Infectious Disease specialist, or physician experienced in the treatment of Hepatitis B.	<input type="checkbox"/>	<input type="checkbox"/>
5. Is patient a candidate for Interferon or lamivudine? If no, please provide a reason why member is not a candidate for this therapy.	<input type="checkbox"/>	<input type="checkbox"/>
6. Has patient failed or has a contraindication to lamivudine therapy or lamivudine mutants suspected. Please provide a list of the dates of therapy and chart notes to document.	<input type="checkbox"/>	<input type="checkbox"/>
7. HIV status of the patient is known. If unknown, HIV test must be completed prior to approval.	<input type="checkbox"/>	<input type="checkbox"/>
8. Patient has history of hypersensitivity to any of the components of the product.	<input type="checkbox"/>	<input type="checkbox"/>
<b>Initial approval will be for 6 months (24 weeks) subject to virological response. Serology (i.e., HBeAg, HBeAb, HBV-DNA, ALT/AST) should be measured at 12 and 24 weeks to determine patient response. Approval for responders as assessed at 6 months will then be granted for 12 month periods.</b>		
<b>Quantity Limits: 30 tablets per RX filled</b>		

DISPENSE IN ONLY 30 DAYS SUPPLY

Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Duration of Therapy: \_\_\_\_\_

PRESCRIBER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

*By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.*