

**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: Date of labwork: _____ HBsAg: _____ HBeAg: _____ ALT/AST Level: _____ HBeAb: _____ HBV-DNA: _____	Circle one for each HBsAg: (+) (-) HBeAg: (+) (-) HBeAb: (+) (-) HBV-DNA:(+) (-)	
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"/>
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.		
Quantity Limits: 30 tablets per RX filled		

Dose: _____ Frequency: _____ Duration of Therapy: _____

PRESCRIBER SIGNATURE _____ DATE _____

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