



# Molina Healthcare Hepatitis B Drugs Prior Authorization Request Form

Allow 24 hours or 1 business day to process

Phone: (800) 526-8196 X127854 FAX: (866) 508-6445

## PATIENT INFORMATION:

Member Name (First, Last, MI):

Contact Phone Number:

Molina Identification Number:

Date of Birth:

Gender:

Height:

Weight:

## PRESCRIBER INFORMATION:

Prescriber Name & Specialty:

NPI number:

Phone Number:

Fax Number:

## PHARMACY INFORMATION:

Pharmacy Name:

Pharmacy NPI:

Phone Number:

Fax Number:

## MEDICATION REQUESTED: (LIMIT ONE MEDICATION REQUEST PER FORM)

\* The Molina Formulary is available to download onto your PDA at [www.ePocrates.com](http://www.ePocrates.com) or [www.Molinahealthcare.com](http://www.Molinahealthcare.com)

Drug name, strength, quantity, and dosing directions (**GENERIC EQUIVALENT IS MANDATORY UNLESS OTHERWISE INDICATED**)

<input type="checkbox"/> <b>Baraclude</b> <input type="checkbox"/> 0.5mg <input type="checkbox"/> 1mg <input type="checkbox"/> 0.05mg/mL <b>Dosing Directions &amp; Quantity</b>	<input type="checkbox"/> <b>Epivir HBV</b> <input type="checkbox"/> 100mg <input type="checkbox"/> 5mg/mL <b>Dosing Directions &amp; Quantity</b>	<input type="checkbox"/> <b>Hepsera</b> 10mg <b>Dosing Directions &amp; Quantity</b>	<input type="checkbox"/> <b>Tyzeka</b> 600mg <b>Dosing Directions &amp; Quantity</b>
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\*please note: Viread & Truvada should be billed to Medi-Cal FFS.

## DIAGNOSIS:

- Hepatitis B (HBV)  
 Pre-Core mutant Hepatitis B (HBV)

Is this member therapy naive? Yes  No

Is the member currently receiving the requested medication? Yes  No

If no, is this member receiving another Hepatitis B agent? Yes  No

If yes, list the medication: \_\_\_\_\_

## REQUIRED LAB:

Lab Value	Baseline (pre-treatment)	24 -week (6 month)	48-week (12 month)	72-week (18 month)	96-week (24 month)	____-week (____ month)
Date Labs Drawn						
HBsAg (+/-)						
HBeAb (+/-)						
HbeAg (+/-)						
HBV DNA (iu/mL)						
ALT						
Anti-viral resistant HBV (Y/N)						

- Yes  No Liver Biopsy Results: \_\_\_\_\_  
 Yes  No Member is listed for liver transplant  
 Yes  No Member has decompensated cirrhosis  
 Yes  No Member has a family history of cirrhosis  
 Yes  No Request is for combination therapy with \_\_\_\_\_ and \_\_\_\_\_

## PRESCRIBER'S SIGNATURE: \_\_\_\_\_

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Updated on August 18, 2010