

**Physician's Prior Authorization Questionnaire
Baraclude®**

Patient:

ID#:

DOB:

Patient Address:

Baraclude® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis? *(Please do not use codes.)* _____

2. What prior medications has this patient tried for this diagnosis? _____

3. Will other medications be used for this diagnosis while on Baraclude®? Yes No

If Yes, please list: _____

4. Does the patient currently have active viral replication? Yes No

If Yes, please provide documentation: _____

5. Has the patient shown persistent elevations in serum ALT or AST? Yes No

If Yes, please provide documentation: _____

6. Does the patient currently have histologically active disease? Yes No

If Yes, please provide documentation: _____

Physician's Signature

Date

Please **Print** Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx