

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

Patient:

ID#:

DOB:

Patient Address:

Hepsera® 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. Does the patient have evidence of:

- Active viral replication? Yes No
- Persistent elevations in ALT or AST? Yes No
- Histologically active disease? Yes No

3. Has the patient been treated for HBV prior to this request? Yes No

If Yes, please describe the previous treatment and duration: _____

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