

**Neighborhood Health Plan of Rhode Island
Prior Authorization Request Form
Baraclude® (Entecavir)**

Date of Request: _____

If approval criteria are met, Neighborhood Health Plan of Rhode Island will authorize coverage of Baraclude® (Entecavir). Failure to fill out this form will result in a rejection of this medication at the pharmacy. Thank you for your assistance.

Please complete the following information:

Member Name: (required)	Member ID Number: (required) <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>										
Member Date of Birth: (required) / /	Member Sex: M F (Circle One)										
Prescriber Name: (required)	Contact Person at Office:										
Office Phone number: (required) () -	Office Fax Number: (required) () -										

ASSESSMENT OF BENEFIT NEED:

1. Please describe which indication entecavir will be treating:
 - Chronic hepatitis B virus; nucleoside-treatment naive
 - Hepatitis B viremia during lamivudine therapy
 - Lamivudine resistant Hepatitis B

2. Prescriber is an Infectious Disease Specialist or Gastroenterologist. YES NO
3. The patient at least 16 years old. YES NO
4. Please indicate the patient's most recent creatinine clearance (CrCl) in the box at the right and provide the date of the most recent test:

CrCl:

Test Date: ____ / ____ / ____

5. Is this patient considered at high risk for hepatotoxicity with Hepsera? YES NO
6. This patient has demonstrated resistance to Hepsera. YES NO

BENEFIT TERMS UPON APPROVAL:

Only the tablet formulation will be covered by NHPRI as the need for a liquid formulation in a population ≥ 16 years of age is likely to be limited and can be addressed on a case by case basis. If approved, entecavir will be authorized initially for six months, then yearly renewal if therapy is successful in meeting physician defined outcomes.

All information provided on this form is accurate as of this date.

Provider Signature: _____ **NPI:** _____ **Date:** _____

**Completed forms should be faxed to:
Customer Service Department
NHPRI
866-423-0945**