

## Vemlidy (tenofovir alafenamide) Prior Authorization Request Form



Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

			∐ URG
MEMBER INFORMATION	N		
LAST NAME:		FIRST NAME:	
PHONE NUMBER:		DATE OF BIRTH:	
STREET ADDRESS:			
CITY:		STATE: ZIP CO	DE:
PATIENT INSURANCE ID	NUMBER:		
	HEIGHT (IN/CM): WE		
	RESCRIBER, YOU WILL NEED TO SUBMIT A PHI DING.  RX.COM/MEMBER/EXTERNAL/COMMERCIAL/		
	·		
	REPRESENTATIVE (IF APPLICAB		
AUTHURIZED REPRESENT	'ATIVE'S PHONE NUMBER:		
PRESCRIBER INFORMAT	ION		
LAST NAME:		FIRST NAME:	
PRESCRIBER SPECIALTY:		EMAIL ADDRESS:	
		EMAIL ADDRESS:  DEA NUMBER:	
PRESCRIBER SPECIALTY: NPI NUMBER: PHONE NUMBER:			
NPI NUMBER:		DEA NUMBER:	
NPI NUMBER: PHONE NUMBER:		DEA NUMBER:	DE:
NPI NUMBER: PHONE NUMBER: STREET ADDRESS:		DEA NUMBER:  FAX NUMBER:	
NPI NUMBER: PHONE NUMBER: STREET ADDRESS: CITY:		DEA NUMBER:  FAX NUMBER:  STATE: ZIP CO	
NPI NUMBER: PHONE NUMBER: STREET ADDRESS: CITY: REQUESTOR (if different than		DEA NUMBER:  FAX NUMBER:  STATE: ZIP CO  OFFICE CONTACT PERSO	
NPI NUMBER: PHONE NUMBER: STREET ADDRESS: CITY: REQUESTOR (if different than	prescriber):	DEA NUMBER:  FAX NUMBER:  STATE: ZIP CO  OFFICE CONTACT PERSO	
NPI NUMBER: PHONE NUMBER: STREET ADDRESS: CITY: REQUESTOR (if different than	prescriber):	DEA NUMBER:  FAX NUMBER:  STATE: ZIP CO  OFFICE CONTACT PERSO	
NPI NUMBER: PHONE NUMBER: STREET ADDRESS: CITY: REQUESTOR (if different than MEDICATION OR MEDIC MEDICATION NAME:	prescriber):  CAL DISPENSING INFORMATIO	DEA NUMBER:  FAX NUMBER:  STATE: ZIP CO  OFFICE CONTACT PERSO  DN  LENGTH OF	QUANTITY:

 $\hbox{@ 2017-2023}$  by Magellan Rx Management LLC. All Rights Reserved.

Revision Date: 6/15/2023

CAT0264







## **Vemlidy (tenofovir alafenamide) Prior Authorization Request Form**



Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

MEMBER, 2 FA21 NAME: MEMBER, 2 FIR21 NAME:		
1. HAS THE PATIENT TRIED ANY OTH	ER MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
□ Chronic hepatitis B infection		105 201
□ Other diagnosis:	ICD-10	
3. REQUIRED CLINICAL INFORMATION PRIOR AUTHORIZATION.	N: PLEASE PROVIDE ALL RELEVANT CLIN	NICAL INFORMATION TO SUPPORT A
Clinical Information:		
Does the patient have compensated	l liver disease?*□ Yes □ No	
treatment for HBV?*   Yes   No *Ple  Does the patient have persistent elev pyruvic transaminase [SGPT])?*   Ye  Has patient had a trial of Viread(tend  Does patient have an absolute cont	ONA concentrations of greater than 20, case provide documentation.  Vations of serum alanine aminotransferates   No *Please provide documentation.  ofovir disoproxil fumarate)?   Yes   No raindication to Viread(tenofovir disopromous No *Please provide documentation.	ase (ALT, also known as serum glutamic  *Please provide documentation.
,	al response to Vemlidy therapy?* □ Yes	·
physician feels is important to this re	noses, symptoms, medications tried or face seriew?	alled, and for any other information the
information is received.	are covered on all plans. This request ma	
the Health Plan, insurer, Medical Gro	on provided is true and accurate to the bup or its designees may perform a routine curacy of the information reported on the	•
Prescriber Signature or Electronic I.D	. Verification:	Date:

 $\hbox{@ 2017-2023}$  by Magellan Rx Management LLC. All Rights Reserved.

Revision Date: 6/15/2023

CAT0264







## Vemlidy (tenofovir alafenamide) Prior Authorization Request Form



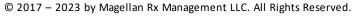
Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

**CONFIDENTIALITY NOTICE:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**FAX THIS FORM TO: 800-424-7640** 

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program

Attn: CP – 4201 P.O. Box 64811 St. Paul, MN 55164-0811



Revision Date: 6/15/2023

CAT0264



