OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare

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Hepcludex® (bulevirtide-gmod) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

Pharmacy billing (NDC: _____***) Start Date (or date of next dose):*** _____

Dose: _____ ***Regimen:*** _____

Pharmacy Information

Pharmacy NPI: _____ ***Pharmacy Name:*** _____

Pharmacy Phone: _____ ***Pharmacy Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

For Initial Authorization:

1. Member's diagnosis:
   - ☐ **Chronic Hepatitis D Virus Infection**
   - ☐ **Other:** _____
2. Please provide the following levels *(results must be submitted with the request)*:
   a. Detectable serum HDV RNA level: _____
   b. Alanine aminotransferase (ALT) levels: _____
3. Does member have decompensated cirrhosis or hepatocellular carcinoma (HCC)? Yes☐ No☐
4. Is Hepcludex® prescribed by a gastroenterologist, hepatologist, or infectious disease specialist? Yes☐ No☐
5. Will underlying hepatitis B virus (HBV) infection be managed as clinically appropriate? Yes☐ No☐
6. Will member or caregiver be trained on proper storage, reconstitution, and administration of Hepcludex®? Yes☐ No☐

For Continued Authorization: *(results of testing must be submitted with the request)*

1. Date of last dose: _____
2. Is member responding well to treatment? Yes☐ No☐
3. Check all that apply:
   - ☐ Undetectable HDV RNA or a ≥2 $\log_{10}$ IU/mL reduction in HDV RNA from baseline
   - ☐ Reduction or normalization of ALT
   - ☐ Member has not developed decompensated cirrhosis or HCC
   - ☐ Member has not undergone a liver transplant

Additional Information: _____

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. *Please do not send in chart notes. Specific information will be requested if necessary.*

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.	CONFIDENTIALITY NOTICE *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*