



**GEORGIA MEDICAID FEE-FOR-SERVICE
HEPATITIS B AGENTS PA SUMMARY**

Preferred	Non-Preferred
<i>Nucleoside Analogs</i>	
Baraclude oral solution (entecavir) Entecavir tablets generic Hepsera (adefovir) Lamivudine HBV generic Tenofovir disoproxil fumarate 300 mg tablets generic Viread Powder and Tablets 150 mg, 200 mg, 250 mg (tenofovir disoproxil fumarate)	Adefovir generic Vemlidy (tenofovir alafenamide)
<i>Interferons</i>	
Intron A (interferon alfa-2b) Pegasys (peginterferon alfa-2a)	

LENGTH OF AUTHORIZATION: 1 year

PA CRITERIA:

Adefovir Generic

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, brand Hepsera, is not appropriate for the member.

Vemlidy

- ❖ Approvable for members 18 years of age or older with a diagnosis of chronic hepatitis B with compensated liver disease who have a history of or are at risk for bone fracture, osteopenia, osteoporosis, osteomalacia or renal impairment; otherwise, prescriber must submit a written letter of medical necessity stating the reasons the preferred products, Viread Powder and generic tenofovir disoproxil fumarate 300 mg tablets, is not appropriate for the member.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827**.

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to <http://dch.georgia.gov/preferred-drug-lists>.



PA and APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Pharmacy and click on [Other Documents](#), then select the most recent quarters QLL List.