Prescriber Criteria Form

Hepatitis B 2025 PA Fax BD-5 v2 010125.docx
Hepatitis B Vaccine
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Hepatitis B Vaccine.

Drug Name:
Hepatitis B Vaccine

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the patient at high or intermediate risk of contracting hepatitis B? - High risk groups currently identified include but are not limited to: Individuals with ESRD (End Stage Renal Disease) Individuals with hemophilia who received Factor VIII or IX concentrates Clients of institutions for individuals with intellectual disabilities (IID) Persons who live in the same household as a hepatitis B virus carrier Men who have sex with men Illicit injectable drug abusers Persons diagnosed with diabetes mellitus - Intermediate risk groups currently identified include but are not limited to: Staff in institutions for individuals with intellectual disabilities (IID) Health care workers with frequent contact with blood or blood-derived body fluids during routine work Individuals who have not previously received a completed hepatitis B vaccine series Individuals with unknown hepatitis B vaccine status	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ Date:_____