



Recombivax HB
(Hepatitis B Virus
Vaccine Recombinant)

Express Scripts
Prior Authorization
Phone 800-417-8164
Fax 877-837-5922

Member's Last Name:	Member's First Name:
SCAN ID number:	Date of Birth:
Prescriber's Name:	Contact Person:
Office phone:	Office Fax:

Medication:	Diagnosis:
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This drug may be covered under Medicare Part B or Part D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

<p>1. Is vaccine administered to a member who is at high or intermediate risk of contracting hepatitis B?</p> <ul style="list-style-type: none">• High risk groups currently identified include: individuals with ESRD; individuals with hemophilia who received Factor VIII or IX concentrates; clients of institutions for individuals for the mentally handicapped; persons who live in the same household as a hepatitis B Virus (HBV) carrier; homosexual men; illicit injectable drug abusers.• Intermediate risk groups include: staff in institutions for the mentally handicapped and workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work.
<p>2. Is vaccine administered to a member who is at low risk of contracting hepatitis B?</p>
<p>3. Are there any other comments, diagnoses, symptoms, and/or any other information the caller feels is important to this review? Note: Please paste "yes" or "no" answer in comments.</p>

Notice: **Failure to provide all information requested on this form may result in delayed processing or an adverse determination for insufficient information.** Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at <http://www.scanhealthplan.com>.