Idaho ADAP Program
Prior Authorization Drug Approval Form
Vemlidy PA form

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH: – –

GENDER: ☐ Male ☐ Female

Drug Name

Strength

Dosing Directions

Length of Therapy

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER: – –

FAX NUMBER: – –

SECTION III: CLINICAL HISTORY

1. **Is Vemlidy being requested for Hepatitis B?** ☐ Yes ☐ No
   If no, what is the diagnosis for it's usage? _____
2. **If Vemlidy is being requested for HIV, will it be used as part of patient's current antiretroviral therapy?** ☐ Yes ☐ No
3. **Please document the patient's creatinine clearance. Date:**_____ **Result:** _____
4.. **Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.**

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

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