



**Prior Authorization Approval Criteria**  
*Department of Pharmacy Services*

**Generic Name:** adefovir

**Brand Name:** Hepsera

**Medication Class:** antiviral- nucleotide analogue, reverse transcriptase inhibitor

**FDA Approved Uses:** Hepatitis B

**Usual Dose:** 10mg PO daily

**Duration of Therapy:** Indefinite

**Criteria for Use:** *(bullet points below are all inclusive unless otherwise noted)*

- Active Hepatitis B
- Active viral replication (Hep Be antigen, Hbe Ag, HBV DNA)
- Active inflammation (increase in serum transaminases)

or

- Fibrotic or inflammatory changes evident on liver biopsy
- Resistance to lamivudine

**Not Approved if:**

- Patient has not tried lamivudine
- Patient does not have active disease
- Patient does not have fibrotic or inflammatory changes
- Patient has renal disease



P&T Approval: \_\_\_\_\_ Date: \_\_\_\_\_