PRIOR AUTHORIZATION REQUEST
Ocaliva

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. What is the diagnosis or indication?
   - ☐ Primary Biliary Cholangitis (PBC) - also known as Primary Biliary Cirrhosis – **Please answer questions 2 – 9**
   - ☐ Alcoholic Liver Disease
   - ☐ Nonalcoholic Fatty Liver Disease (NAFLD), including Nonalcoholic Fatty Liver (NAFL) or Nonalcoholic Steatohepatitis (NASH)
   - ☐ All others – Please specify _____
2. ☐ Yes ☐ No Is the patient currently receiving therapy?
3. ☐ Yes ☐ No Is Ocaliva being prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician?
4. ☐ Yes ☐ No Has the patient responded to Ocaliva therapy as determined by the prescriber?
5. ☐ Yes ☐ No Has the patient been receiving ursodiol therapy for GREATER THAN OR EQUAL to one year and has had an inadequate response according to the prescribing physician?
6. ☐ Yes ☐ No According to the prescriber is the patient unable to tolerate ursodiol therapy?
7. ☐ Yes ☐ No Is the patient's alkaline phosphatase (ALP) elevated above the upper limit of normal as defined by normal laboratory reference values?
8. ☐ Yes ☐ No Does the patient have positive anti-mitochondrial antibodies (AMAs) or other PBC-specific auto-antibodies, including sp100 or gp210, if AMA is negative?
9. ☐ Yes ☐ No Is there histologic evidence of primary biliary cholangitis (PBC) from a liver biopsy?

Please document the diagnoses, symptoms, and/or any other information important to this review:

_____

_____

If you have any questions, call: 800-753-2851

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SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

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If you have any questions, call: 800-753-2851