maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Livmarli

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1	What is the diagnosis or indication? [] Alagille Syndrome (If checked, go to 2) [] Other (If checked, no further questions)		
2	Is the requested medication prescribed by or in consultation with a hepatologist, gastroenterologist or a physician who specializes in Alagille syndrome? [If no, no further questions.]	Yes	No
3	Does the patient have cirrhosis? [If yes, no further questions.]	Yes	No

If you have any questions, call:
1-888-258-8250

PRIOR AUTHORIZATION REQUEST

4	Does the patient have portal hypertension? [If yes, no further questions.]	Yes	No
5	Does the patient have history of a hepatic decompensation event? [Note: Examples of a hepatic decompensation event include variceal hemorrhage, ascites, and hepatic encephalopathy.] [If yes, no further questions.]	Yes	No
6	Is the patient currently receiving the requested medication? [If no, skip to question 10.]	Yes	No
7	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 10.]	Yes	No
8	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 10.]	Yes	No
9	Has documentation been provided to confirm that there is positive clinical response for the patient with improvement from baseline for the following: A) Reduced serum bile acids; B) Reduced pruritus severity score? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
10	Is the patient greater than or equal to 1 years of age? [If no, no further questions.]	Yes	No
11	Does the patient have moderate-to-severe pruritus, according to prescriber? [If no, no further questions.]	Yes	No
12	Was the diagnosis of Alagille syndrome confirmed by genetic testing demonstrating a JAG1 or NOTCH2 deletion or mutation? [If no, no further questions.]	Yes	No
13	Does the patient have evidence of cholestasis that is met by conjugated bilirubin GREATER THAN 1 mg/dL? [If yes, skip to question 18.]	Yes	No
14	Does the patient have evidence of cholestasis that is met by gamma glutamyl transferase (GGT) GREATER THAN 3 time's upper limit of normal for age? [If yes, skip to question 18.]	Yes	No
15	Does the patient have evidence of cholestasis that is met by serum bile acid concentration GREATER THAN 3 time's upper limit of normal for age? [If yes, skip to question 18.]	Yes	No

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16	Does the patient have evidence of cholestasis that is met by fat-soluble vitamin deficiency that is unexplainable? [If yes, skip to question 18.]	Yes	No
17	Does the patient have evidence of cholestasis that is met by intractable pruritus with all other causes ruled out and explainable only by liver disease? [If no, no further questions.]	Yes	No
18	Does the patient have a serum bile acid concentration above the upper limit of the normal reference range for the reporting laboratory? [If no, no further questions.]	Yes	No
19	Has documentation been provided to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with Ursodiol (ursodeoxycholic acid)? ACTION REQUIRED: Submit supporting documentation. [If yes, no further questions.]	Yes	No
20	Has documentation been provided to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with two different medications used for pruritus? ACTION REQUIRED: Submit supporting documentation.	Yes	No

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

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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