maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Bylvay

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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	What is the diagnosis or indication? [] Progressive Familial Intrahepatic Cholestasis (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 progressive familial intrahepatic cholestasis? [If no, no further questions.]	Yes	No

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

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3	Does the patient have cirrhosis? [If yes, no further questions.]	Yes	No
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 submitted to confirm that there is clinical response of the patient's condition which has stabilized or improved based upon the prescriber's assessment for the following: A) Decrease in serum bile acids; B) Decrease in pruritus? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
10	Is the patient 3 months of age or older? [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 progressive familial intrahepatic cholestasis confirmed by genetic testing demonstrating a gene mutation affiliated with progressive familial intrahepatic cholestasis? [Note: Gene mutations affiliated with progressive familial intrahepatic cholestasis include the *ATP8B1* gene, *ABCB11* gene, *ABCB4* gene, *TJP2* gene, *NR1H4* gene, and *MYO5B* gene.] [If no, no further questions.]	Yes	No
13	Does the patient have a *ABCB11* variant resulting in non-functional or complete absence of bile salt export pump protein (BSEP-3)? [If yes, no further questions.]	Yes	No

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14	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
15	Has documentation been submitted 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 no, no further questions.]	Yes	No
16	Has documentation been submitted 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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