PRIOR AUTHORIZATION REQUEST

Ocaliva

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?

[] Primary Biliary Cholangitis (PBC) - also known as Primary Biliary Cirrhosis (If checked, go to 2)

[] Alcoholic Liver Disease (If checked, no further questions)

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

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	[] Nonalcoholic Fatty Liver Disease (NAFLD), including Nonalcoholic Fatty Liver (NAFL) or Nonalcoholic Steatohepatitis (NASH) (If checked, no further questions) [] All others (If checked, no further questions)		
2	Is the patient currently receiving therapy? [If yes, skip to question 5.]	Yes	No
3	Is the patient greater than or equal to 18 year(s) of age? [If no, no further questions.]	Yes	No
4	Is the requested medication being prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician? [If yes, skip to question 6.] [If no, no further questions.]	Yes	No
5	Has the patient responded to Ocaliva therapy as determined by the prescriber? [No further questions.] [NOTE: Examples of a response to Ocaliva therapy are improved biochemical markers of primary biliary cholangitis [PBC] (for example, alkaline phosphatase (ALP), bilirubin, gamma-glutamyl transpeptidase (GGT), aspartate aminotransferase (AST), alanine aminotransferase (ALT) levels).]	Yes	No
6	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? [If yes, skip to question 8.] [NOTE: Examples of ursodiol therapy include ursodiol generic tablets and capsules, Urso 250,Urso Forte and Actigall.]	Yes	No
7	Is the patient unable to tolerate ursodiol therapy? [If no, no further questions.]	Yes	No
8	Is the patient's alkaline phosphatase (ALP) elevated above the upper limit of normal as defined by normal laboratory reference values? [If no, skip to question 10.]	Yes	No
9	Does the patient have positive anti-mitochondrial antibodies (AMAs) or other PBC-specific autoantibodies, including sp100 or gp210, if AMA is negative? [If yes, no further questions.] [If no, skip to question 11.]	Yes	No
10	Does the patient have positive anti-mitochondrial antibodies (AMAs) or other PBC-specific autoantibodies, including sp100 or gp210, if AMA is negative? [If no, no further questions.]	Yes	No

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11	Is there histologic evidence of primary biliary cholangitis (PBC) from a liver biopsy?	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.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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