PRIOR AUTHORIZATION REQUEST

CTEXLI

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.

CRITERIA FOR APPROVAL

1 Is the request an INITIAL or CONTINUATION of therapy?
[] Initial (If checked, go to 8)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 8.]

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

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3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 8.]	Yes	No
4	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 8.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 8.]	Yes	No
6	Does the patient have documentation of liver function tests within the last 3 months, showing alanine transaminase and aspartate transaminase (ALT/AST) less than or equal to 3 times upper limit of normal (ULN)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
7	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy as determined by the provider (e.g., a reduction in plasma cholestanol, urine 23S-pentol from baseline, or improvement in clinical symptoms)? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
8	Is the patient 18 year of age or older? [If no, no further questions.]	Yes	No
9	What is the diagnosis? [] Cerebrotendinous Xanthomatosis (CTX) (If checked, go to 10) [Note: Must provide a confirmed CTX diagnosis via a genetic testing confirming CYP27A1 mutation or biochemical evidence of elevated plasma cholestanol and urine 23S-pentol (cholestanol greater than or equal to 6.5 microgram per milliliter and urine 23S-pentol greater than or equal to 15 micromoles per liter).] [] Gallstone dissolution (If checked, no further questions)		
10	Does the patient have severe hepatic impairment (Child-Pugh C) or alanine transaminase and aspartate transaminase (ALT/AST) greater than 3 times upper limit of normal (ULN)? ACTION REQUIRED: Submit supporting documentation. [If yes, no further questions.]	Yes	No
11	Has documentation been submitted to confirm baseline alanine transaminase and aspartate transaminase (ALT/AST) and total bilirubin levels within the last 3 months? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No

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12	Does the patient have any bile duct abnormalities or bilirubin levels greater than 2 times upper limit of normal (ULN)? ACTION REQUIRED: Submit supporting documentation. [If yes, no further questions.]	Yes	No
13	Does the provider attest that the patient will not be receiving cholic acid or concomitant medications which impact bile acid absorption (e.g. bile acid sequestrants or aluminum-based antacids)? [If no, no further questions.]	Yes	No
14	Is the requested medication being prescribed by or in consultation with a physician who specializes in the treatment of cerebrotendinous xanthomatosis (CTX)? [If no, no further questions.]	Yes	No
15	Does the prescribed dosing exceed the Food and Drug Administration (FDA) approved dose for the indication?	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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