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. 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 Is the request for an INITIAL or a CONTINUATION of therapy?

[] Initial (If checked, go to 7)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 7.]

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3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 7.]	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 7.]	Yes	No
5	Has the patient been established on therapy for AT LEAST 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	Is the requested medication prescribed by or in consultation with a hepatologist, gastroenterologist or a physician who specializes in Alagille syndrome or Progressive Familial Intrahepatic Cholestasis (PFIC)? [If no, no further questions.]	Yes	No
8	Does the patient have cirrhosis? [If yes, no further questions.]	Yes	No
9	Does the patient have portal hypertension? [If yes, no further questions.]	Yes	No
10	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
11	What is the diagnosis or indication? [] Alagille Syndrome (If checked, go to 12) [] Cholestatic pruritus with Progressive Familial Intrahepatic Cholestasis (PFIC) (If checked, go to 25) [] Other (If checked, no further questions)		
12	Is the patient greater than or equal to 3 months of age? [If no, no further questions.]	Yes	No
13	Does the patient have moderate-to-severe pruritus, according to prescriber? [If no, no further questions.]	Yes	No

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14	Was the diagnosis of Alagille syndrome confirmed by genetic testing demonstrating a Jagged1 (JAG1) or Notch Receptor 2 (NOTCH2) deletion or mutation? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Does the patient have evidence of cholestasis that is met by conjugated bilirubin GREATER THAN 1 mg/dL? [If yes, skip to question 20.]	Yes	No
16	Does the patient have evidence of cholestasis that is met by gamma glutamyl transferase (GGT) GREATER THAN 3 times upper limit of normal for age? [If yes, skip to question 20.]	Yes	No
17	Does the patient have evidence of cholestasis that is met by serum bile acid concentration GREATER THAN 3 times upper limit of normal for age? [If yes, skip to question 20.]	Yes	No
18	Does the patient have evidence of cholestasis that is met by fat-soluble vitamin deficiency that is unexplainable? [If yes, skip to question 20.]	Yes	No
19	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
20	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
21	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, skip to question 23.]	Yes	No
22	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. [If no, no further questions.]	Yes	No
23	Is the requested medication being prescribed by, or in consultation with, a hepatologist or gastroenterologist? [If no, no further questions.]	Yes	No
24	Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved labeled dosing? [Note: Dosing: Max dose of 380 mcg/kg once daily.] [No further questions.]	Yes	No

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25	Is the patient greater than or equal to 12 months of age? [If no, no further questions.]	Yes	No
26	Does the patient have a documented diagnosis of Progressive Familial Intrahepatic Cholestasis (PFIC) - subgroup type 2 with ABCB11 variants encoding for nonfunction or absence of bile salt export pump protein (BSEP-3)? [If yes, no further questions.]	Yes	No
27	Does the patient have a confirmed diagnosis of progressive familial intrahepatic cholestasis (PFIC) (For example, mutations in ATP8B1, ABCB11, ABCB4, TJP2, MYO5B)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
28	Does the patient have moderate-to-severe pruritus, according to prescriber? [If no, no further questions.]	Yes	No
29	Does the patient have evidence of cholestasis that is met by serum bile acid concentration GREATER THAN 3 times upper limit of normal for age? [If no, no further questions.]	Yes	No
30	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, skip to question 32.]	Yes	No
31	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 (In addition to Ursodiol) used for pruritus? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
32	Is the requested medication being prescribed by, or in consultation with, a hepatologist or gastroenterologist? [If no, no further questions.]	Yes	No
33	Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved labeled dosing? [Note: Dosing: Max dose for the oral solution is 38 mg per day and for the tablet is 40 mg per day.]	Yes	No

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

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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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