Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Ocaliva® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Primary biliary cholangitis (PBC)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Select if the patient has documentation of the following:

- ❑ Anti-mitochondrial antibody (AMA): a titer of 1:40 or higher or a level that is above the laboratory upper limit of normal range
- ❑ Biochemical evidence of cholestasis with an alkaline phosphatase elevation of at least 1.5 times the upper limit of normal
- ❑ Evidence of non-suppurative destructive cholangitis and destruction of interlobular bile ducts

Labs/progress notes must be attached

Will the patient's baseline alkaline phosphatase (ALP) level, within the last 60 days of request, be submitted? ❑ **Yes** ❑ **No**
Labs must be submitted

Will the patient's baseline total bilirubin level, within the last 60 days of request, be submitted? ❑ **Yes** ❑ **No**
Labs must be submitted

Has the patient been established on ursodeoxycholic acid (UDCA) within the last 12 months? ❑ **Yes** ❑ **No**
Paid pharmacy claims will be verified

Are the patient's alkaline phosphatase and total bilirubin levels still above the upper limit of normal while established on ursodeoxycholic acid (UDCA)? ❑ **Yes** ❑ **No**
Labs done within the last 30 days must be submitted

Is the patient taking ursodeoxycholic acid (UDCA) in combination with the requested medication due to ALP and total bilirubin levels remaining above the upper limit of normal after 6 months of paid claims for ursodeoxycholic acid? ❑ **Yes** ❑ **No**

Does the patient have complete biliary obstruction? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following:

Has the patient's alkaline phosphatase (ALP) level decreased by at least 15% from baseline? ❑ **Yes** ❑ **No**
Labs done within the last 30 days must be submitted

Has the patient's alkaline phosphatase (ALP) level decreased to less than 1.67 times the upper limit of normal? ❑ **Yes** ❑ **No**
Labs done within the last 30 days must be submitted

Has the patient's total bilirubin level decreased to less than or equal to the upper limit of normal? ❑ **Yes** ❑ **No**
Labs done within the last 30 days must be submitted

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Ocaliva® Prior Authorization Request Form (Page 2 of 2)

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Quantity limit requests:

What is the quantity requested per DAY? _____

Previous therapies failed and/or therapies currently used in combination with the requested medication (*List ALL medications tried or authorization process will be delayed)*:_____

_____

_____

Is the prescribed dose higher than the maximum dose recommendation in FDA-approved labeling (i.e., the package insert)? ❑ **Yes** ❑ **No**

If **Yes**, please provide documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature).

*** Please note: Chart documentation of the above is required to be submitted along with this fax*

_____

_____

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Prescriber Signature: _____ **Date:** _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.