Please complete ALL information below and fax your request to 1-888-671-5285

Ocaliva® Prior Authorization Request Form

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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 **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Primary biliary cholangitis (also known as primary biliary cirrhosis)

❑ Other diagnosis: ____ ICD-10 Code(s): __________________________________

Clinical Information:

Has the patient failed to achieve an alkaline phosphatase (ALP) level less than 1.67 times the upper limit of normal (ULN) after at least 12 consecutive months of treatment with ursodeoxycholic acid (UDCA) (e.g., Urso, Urso Forte, ursodiol)? ❑ **Yes** ❑ **No**

Will Ocaliva be used in combination with ursodeoxycholic acid (UDCA)? ❑ **Yes** ❑ **No**

Is Ocaliva prescribed by or in consultation with a hepatologist or gastroenterologist? ❑ **Yes** ❑ **No**

Does the patient have moderate to severe hepatic impairment (Child-Pugh class B or C)? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had a reduction in ALP level from pre-treatment baseline (i.e., prior Ocaliva therapy) while on Ocaliva therapy?* ❑ **Yes** ❑ **No**

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

Does the patient have moderate to severe hepatic impairment (Child-Pugh class B or C)? ❑ **Yes** ❑ **No**

Quantity Limit Requests:

What is the quantity requested per MONTH? ________

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes

❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ Other: ____

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

____

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Please note: This request may be denied unless all required information is received.

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