

CHOLESTASIS PRURITUS PRIOR AUTHORIZATION PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today's Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:		Group Number:	

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:		Clinic Address:	
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis:

- Progressive familial intrahepatic cholestasis (PFIC) with pruritus **(Medical records required)**
- Alagille syndrome (ALGS) with pruritus **(Medical records required)**
- Other (ICD code, plus description): _____

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

- What is the patient's weight? _____ (kg)
- Is the patient currently treated with the requested agent?..... Yes No
- Does the patient have any FDA labeled contraindications to the requested agent?..... Yes No
If yes, please specify contraindications: _____
- Is the prescriber a specialist in the area of the patient's diagnosis (e.g., gastroenterologist, hepatologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? Yes No
- Will the patient be using the requested agent in combination with another Ilea Bile Acid Transport (IBAT) inhibitor agent (e.g., Livmarli, Bylvay) for the requested indication? Yes No
- Is the patient's age within FDA labeling for the requested indication for the requested agent?..... Yes No
If no, please provide support for using the requested agent for the patient's age for the requested indication: _____
- Does the patient have a serum bile acid concentration above the upper limit of normal (ULN)? Yes No
- Has the patient had a liver transplant? Yes No
If yes, is there support for using the requested agent post liver transplant? Yes No
If yes, please provide supporting information: _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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9. Has the patient tried and had an inadequate response to ONE prerequisite agent? The prerequisite agents are cholestyramine, naltrexone, rifampicin, sertraline, and ursodiol Yes No

If yes, please specify agent: _____

If no, does the patient have an intolerance or hypersensitivity to ONE prerequisite agent? The prerequisite agents are cholestyramine, naltrexone, rifampicin, sertraline, and ursodiol..... Yes No

If yes, please explain intolerance/hypersensitivity: _____

If no, does the patient have an FDA labeled contraindication to ALL prerequisite agents? The prerequisite agents are cholestyramine, naltrexone, rifampicin, sertraline, and ursodiol Yes No

If yes, please specify FDA labeled contraindication: _____

10. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____

For Alagille syndrome (ALGS) with pruritus requests:

11. Are there medical records showing the patient has a diagnosis of Alagille syndrome (ALGS) with pruritus? Yes No

If yes, please submit required medical records for review.

For Progressive familial intrahepatic cholestasis (PFIC) with pruritus requests:

12. Are there medical records showing the patient has a diagnosis of progressive familial intrahepatic cholestasis (PFIC) with pruritus?..... Yes No

If yes, please submit required medical records for review.

13. Does the patient have a diagnosis of PFIC2 with ABCB11 variants resulting in non-functional or complete absence of bile salt export pump protein (BSEP-3)?..... Yes No

For Bylvay (odevixibat) requests:

14. Is the patient's INR less than 1.4?..... Yes No

15. Does the patient have an ALT and total bilirubin that is less than 10-times the upper limit of normal (ULN)? Yes No

For Livmarli (maralixibat) requests:

16. Has the patient had surgical interruption of the enterohepatic circulation of bile acid? Yes No

For renewal requests:

17. Has the patient had clinical benefit with the requested agent? Yes No

Please fax or mail this form to:
 Prime Therapeutics LLC
 Clinical Review Department
 2900 Ames Crossing Road Suite 200
 Eagan, MN 55121

TOLL FREE

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