# PRIOR AUTHORIZATION REQUEST FORM

**EOC ID:**

## Ocaliva (obeticholic acid)

**Phone: 800-728-7947     Fax back to: 866-880-4532**

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

| **Patient Name:** | **Prescriber Name:**<br>**Supervising Physician:** | |
|---|---|---|
| Member/Subscriber Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| Group Number: | NPI: | State Lic ID: |
| Address: | Address: | |
| City, State ZIP: | City, State ZIP: | |
| Primary Phone: | Specialty/facility name (if applicable): | |

Drug Name and Strength:

Directions / SIG:

**Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.**

Q1. Does the patient have a diagnosis of primary biliary cholangitis (PBC)?

☐ Yes ☐ No

Q2. Please provide ICD code(s) for diagnosis.

Q3. Is the patient a new start to therapy?

☐ Yes ☐ No

Q4. Is the patient's PBC confirmed by any of the following? Please select all that apply

☐ Alkaline phosphatase (ALP) at least 1.5 times the upper limit of normal (ULN)
☐ Presence of antimitochondrial antibodies (AMA) at a titer of 1:40 or higher (or above ULN for that lab)
☐ Histologic evidence of nonsuppurative destructive cholangitis and destruction of interlobular bile ducts
☐ Other (please specify)
☐ Not applicable - patient does not have PBC

Q5. Does the patient have failure of ursodiol therapy defined as ALP greater than 1.67 times ULN after 12 months of therapy?

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☐ Yes ☐ No

Q6. Will the patient be using Ocaliva in combination with ursodiol?

☐ Yes ☐ No

Q7. Does the patient have contraindication or clinically significant intolerance to ursodiol?

☐ Yes ☐ No

Q8. What is the patient's cirrhosis status?

☐ Non-cirrhotic
☐ Compensated cirrhosis
☐ Decompensated cirrhosis

Q9. What is the patient's Child Pugh score?

☐ Class A ☐ Class B ☐ Class C

Q10. If the request is for continuation of therapy, does the patient have documented clinical response defined as one of the following? Please select all that apply and provide documentation.

☐ ALP decrease of at least 15% from baseline
☐ ALP < 1.67 ULN
☐ Total bilirubin less than or equal to ULN
☐ Other (please specify)

Q11. Additional Comments

Prescriber Signature

Date

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□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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