pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

BILE SALTS PRIOR AUTHORIZATION FORM

- **Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request.**
- Prior authorization guidelines and quantity limits may be found in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapters – **Bile Salts** and **Quantity Limits/Daily Dose Limits** accessible on the Department's Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION INFORMATION		**PRESCRIBER INFORMATION**	
☐New request ☐Additional info ☐Renewal request PA# _____	# pgs in request: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:
☐Actigall capsule
☐Chenodal tablet
☐Urso tablet
☐Urso Forte tablet
☐_____

For *Cholbam*, please use the *Cholbam Prior Authorization Form.*
For *Ocaliva*, please use the *Ocaliva Prior Authorization Form.*

Strength:	Dose/directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	

1. Does the Recipient have a history of trial and failure of the preferred Bile Salts? *Check all that apply.* ☐ursodiol capsule ☐ursodiol tablet	☐Yes – *submit all supporting documentation of preferred agents tried and treatment outcomes.* ☐No
2. Does the recipient have any contraindications or intolerances of the preferred Bile Salts listed in question (1)?	☐Yes – *submit all supporting documentation of contraindications or intolerances.* ☐No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: