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

CHOLBAM (cholic acid) 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 REQUEST INFORMATION			PRESCRIBER INFORMATION	
☐New request ☐Renewal request	☐Additional info PA#:____________	# of pages 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

Drug requested: Cholbam capsule	Strength:	Quantity:
Directions:		Refills:
Diagnosis:		Dx code *(required)*:

Section A: Initial Cholbam requests	
1. If prescriber is NOT a hepatologist or pediatric gastroenterologist, is the requested medication being prescribed in consultation with one of the above specialists?	☐Yes – *submit documentation of consultation* ☐No or not applicable
2. Does the Recipient have one of the following diagnoses? ☐bile acid synthesis disorder (BASD) due to a single enzyme defect (SED) ☐peroxisomal disorder (PD) (including Zellweger spectrum disorder)	☐Yes – *submit results and dates of mass spectrometry or other biochemical or genetic testing* ☐No – *submit documentation supporting the use of Cholbam for Recipient's diagnosis*
3. ***For a diagnosis of peroxisomal disorder***, will Cholbam be used in addition to other therapy/treatment?	☐Yes – *submit documentation of concurrent therapy or treatment* ☐No
4. Does the Recipient have results of the following baseline (before starting Cholbam) lab tests? ☐AST ☐GGTP ☐bilirubin ☐ALT ☐alkaline phosphatase ☐INR	☐Yes – *submit results and dates of all lab monitoring for all requested values* ☐No

Section B: Renewal Cholbam requests		
1. Does the recipient have documentation of the following lab results since starting Cholbam and within the past 6 months? ☐AST ☐GGT ☐bilirubin ☐ALT ☐alkaline phosphatase ☐INR		☐Yes – *submit results and dates of all lab monitoring for all requested values* ☐No
2. Has the Recipient shown clinical signs or symptoms or lab indicators of any of the following since starting Cholbam?	☐complete biliary obstruction ☐persistent or ongoing worsening of liver function ☐persistent or ongoing cholestasis	☐Yes ☐No *Submit medical record documentation of clinical monitoring*
3. ***For the FIRST RENEWAL REQUEST after starting or restarting Cholbam***, has the Recipient experienced an improvement in liver function within the first 3 months of treatment?		☐Yes – *submit results and dates of baseline LFTs and LFTs drawn 3 months after starting/restarting Cholbam* ☐No

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

Prescriber Signature:	**Date**:

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