

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 <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

PRIOR AUTHORIZATION REQUEST INFORMATION			PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request: _____	Prescriber name: _____	
<input type="checkbox"/> Renewal request	PA#: _____		Specialty: _____	
Name of office contact: _____			State license #: _____	
Contact's phone number: _____			NPI: _____	MA Provider ID#: _____
LTC facility contact/phone: _____			Street address: _____	
RECIPIENT INFORMATION			Suite #: _____	City/state/zip: _____
Recipient name: _____			Phone: _____	
Recipient ID#: _____	DOB: _____		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?	<input type="checkbox"/> Yes – <u>submit documentation of consultation</u> <input type="checkbox"/> No or not applicable
2. Does the Recipient have one of the following diagnoses? <input type="checkbox"/> bile acid synthesis disorder (BASD) due to a single enzyme defect (SED) <input type="checkbox"/> peroxisomal disorder (PD) (including Zellweger spectrum disorder)	<input type="checkbox"/> Yes – <u>submit results and dates of mass spectrometry or other biochemical or genetic testing</u> <input type="checkbox"/> No – <u>submit documentation supporting the use of Cholbam for Recipient's diagnosis</u>
3. For a diagnosis of peroxisomal disorder , will Cholbam be used in addition to other therapy/treatment?	<input type="checkbox"/> Yes – <u>submit documentation of concurrent therapy or treatment</u> <input type="checkbox"/> No
4. Does the Recipient have results of the following baseline (before starting Cholbam) lab tests? <input type="checkbox"/> AST <input type="checkbox"/> GGTP <input type="checkbox"/> bilirubin <input type="checkbox"/> ALT <input type="checkbox"/> alkaline phosphatase <input type="checkbox"/> INR	<input type="checkbox"/> Yes – <u>submit results and dates of all lab monitoring for all requested values</u> <input type="checkbox"/> 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? <input type="checkbox"/> AST <input type="checkbox"/> GGT <input type="checkbox"/> bilirubin <input type="checkbox"/> ALT <input type="checkbox"/> alkaline phosphatase <input type="checkbox"/> INR	<input type="checkbox"/> Yes – <u>submit results and dates of all lab monitoring for all requested values</u> <input type="checkbox"/> No
2. Has the Recipient shown clinical signs or symptoms or lab indicators of any of the following since starting Cholbam? <input type="checkbox"/> complete biliary obstruction <input type="checkbox"/> persistent or ongoing worsening of liver function <input type="checkbox"/> persistent or ongoing cholestasis	<input type="checkbox"/> Yes <u>Submit medical record documentation of clinical monitoring</u> <input type="checkbox"/> No
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?	<input type="checkbox"/> Yes – <u>submit results and dates of baseline LFTs and LFTs drawn 3 months after starting/restarting Cholbam</u> <input type="checkbox"/> No

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

Prescriber Signature: _____	Date: _____
------------------------------------	--------------------

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.