

### OCALIVA (obeticholic acid) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Bile Salts** and **Quantity Limits/Daily Dose Limits** are available on the DHS 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"/> Renewal request	Total # of pages: _____	Prescriber name:
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

#### CLINICAL INFORMATION

<b>Drug requested:</b> Ocaliva tablet	Strength:	Quantity:
Directions:		Refills:
Diagnosis:		Dx code (required):

**Specialty Pharmacy Drug Program:** Ocaliva is part of the DHS Specialty Pharmacy Drug Program and is only available from one of the two DHS specialty pharmacies – **Walgreen's Specialty Pharmacy**.

#### Initial Ocaliva requests

1. If prescriber is NOT a hepatologist or gastroenterologist, is the requested medication being prescribed in consultation with one of the above specialists?	<input type="checkbox"/> Yes – <i>Submit documentation of consultation.</i> <input type="checkbox"/> No or not applicable
2. Does the beneficiary have a diagnosis of primary biliary cholangitis (PBC)?	<input type="checkbox"/> Yes – <i>Submit documentation of lab results and medical history supporting diagnosis.</i> <input type="checkbox"/> No – <i>Submit documentation supporting the use of Ocaliva for beneficiary's diagnosis.</i>
3. Does the beneficiary have results of the following baseline (before starting Ocaliva) lab results? <input type="checkbox"/> AST <input type="checkbox"/> GGTP <input type="checkbox"/> bilirubin <input type="checkbox"/> HDL-C <input type="checkbox"/> ALT <input type="checkbox"/> alkaline phosphatase <input type="checkbox"/> INR	<input type="checkbox"/> Yes – <i>Submit results and dates of all lab monitoring for all requested values.</i> <input type="checkbox"/> No
4. Does the beneficiary have a history of trial and failure, contraindication, or intolerance of ursodiol (ursodeoxycholic acid or UDCA)?	<input type="checkbox"/> Yes – <i>Submit all supporting documentation of trial and failure (including doses tried), contraindications, or intolerances with ursodiol.</i> <input type="checkbox"/> No
5. Will the beneficiary be taking Ocaliva in combination with ursodiol?	<input type="checkbox"/> Yes <i>Submit documentation of planned treatment regimen.</i> <input type="checkbox"/> No

#### Renewal Ocaliva requests

6. Does the beneficiary have documentation of the following lab results since starting Ocaliva and within the past 6 months? <input type="checkbox"/> AST <input type="checkbox"/> GGT <input type="checkbox"/> bilirubin <input type="checkbox"/> HDL-C <input type="checkbox"/> ALT <input type="checkbox"/> alkaline phosphatase <input type="checkbox"/> INR	<input type="checkbox"/> Yes – <i>Submit results and dates of all lab monitoring for all requested values.</i> <input type="checkbox"/> No
7. Has the beneficiary shown clinical signs or symptoms or lab indicators of complete biliary obstruction since starting Ocaliva?	<input type="checkbox"/> Yes <i>Submit documentation of clinical monitoring.</i> <input type="checkbox"/> No

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

<b>Prescriber Signature:</b>	<b>Date:</b>
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