

Member Name: {{MEMFIRST}} {{MEMLAST}} DOB: {{MEMBERDOB}} PA Number: {{PANUMBER}}



{{PANUMCODE}}

Ocaliva

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155.** If you have questions regarding the prior authorization, please contact CVS Caremark at 1-866-814-5506. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date:** {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

- What is the diagnosis?
 Primary biliary cholangitis (PBC) (previously known as primary biliary cirrhosis)
 Other _____
- What is the ICD-10 code? _____
- Is the patient currently receiving Ocaliva? Yes No *If No, skip to #5*
- Has the patient achieved or maintained a clinical benefit from Ocaliva therapy [i.e., at least a 15% reduction in alkaline phosphatase (ALP) level, ALP level less than 1.67-times upper limit of normal (ULN), or total bilirubin less than or equal to ULN] since starting therapy with Ocaliva? ***ACTION REQUIRED: If Yes, attach recent lab report with serum alkaline phosphatase (ALP) and/or total bilirubin level(s).***
 Yes No *No further questions*
- Has the diagnosis of PBC been confirmed by at least two of the following three criteria?
 Biochemical evidence of cholestasis with elevation of alkaline phosphatase (ALP) level for at least 6 months duration
 Presence of antimitochondrial antibodies (AMA) (titer greater than 1:40 by immunofluorescence or immunoenzymatic reactivity) or PBC-specific antinuclear antibodies (ANA) (eg, anti-gp210, anti-sp100)
 Histologic evidence of PBC on liver biopsy (eg, non-suppurative inflammation and destruction of interlobular and septal bile ducts)
 Other _____
 None of the above
- Was the patient's serum alkaline phosphatase (ALP) level elevated prior to initiating therapy with Ocaliva? ***ACTION REQUIRED: If Yes, attach pretreatment lab report with serum alkaline phosphatase (ALP) level.***
 Yes No
- Has the patient had an inadequate response to at least 12 months of prior therapy with ursodeoxycholic acid (UDCA)/ursodiol? Yes No *If No, skip to #9*
- Will the patient continue concomitant therapy with UDCA/ursodiol? Yes No *No further questions*

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

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CVS Caremark Prior Authorization • 1300 E. Campbell Road • Richardson, TX 75081

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9. Did the patient experience intolerance to therapy with UDCA/ursodiol? Yes No

If Yes, please indicate type of intolerance: _____

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X

Prescriber or Authorized Signature

Date (mm/dd/yy)

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