

SENTARA HEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Ocaliva® (obeticholic acid)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.
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Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.
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<u>Initial Authorization: 12 months</u>
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- ☐ Is the member currently being treated with the requested medication? ☐ Yes ☐ No

If **YES**, when was the treatment with the requested medication started? _____

AND

- ☐ Baseline alkaline phosphatase (ALP) level must be submitted _____
(labs collected within the last 60 days of request must be submitted)

AND

- ☐ Baseline total bilirubin level must be submitted _____
(labs collected within the last 60 days of request must be submitted)

AND

- ☐ Member must have a confirmed diagnosis of Primary Biliary Cholangitis (PBC) with documentation of at least two of the following (labs/progress notes must be attached):

(Continued on next page)

- ☐ Biochemical evidence of cholestasis with an alkaline phosphatase elevation of at least 1.5 times the upper limit normal
- ☐ Antimitochondrial antibody (AMA): a titer of 1:40 or higher or a level that is above the laboratory upper limit of normal range
- ☐ Evidence of nonsuppurative destructive cholangitis and destruction of interlobular bile ducts

AND

- ☐ Member must be established on ursodeoxycholic acid (UDCA) for the last 8 months consecutively (**paid pharmacy claims for medication will be verified**)

AND

- ☐ Alkaline phosphatase and total bilirubin levels are still above the upper limit of normal while established on ursodeoxycholic acid (UDCA) _____ (**labs collected within the last 30 days must be submitted**)

AND

- ☐ Member must take ursodeoxycholic acid (UDCA) in combination with the requested medication due to ALP and total bilirubin levels remaining above the upper limit of normal after 8 months of consecutive claims for ursodeoxycholic acid

AND

- ☐ Medication will **NOT** be approved if the member has complete biliary obstruction

Reauthorization Approval: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ☐ Member must have monthly pharmacy paid claims for Ocaliva for the last 12 months

AND

- ☐ Alkaline phosphatase (ALP) level must have decreased by at least 15% from baseline (**labs collected within the last 30 days must be submitted**)

OR

- ☐ Alkaline phosphatase (ALP) level must have decreased to less than 1.67 times the upper limit of normal (**labs collected within the last 30 days must be submitted**)

AND

- ☐ Total bilirubin level must have decreased to less than or equal to the upper limit of normal (**labs collected within the last 30 days must be submitted**)

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****Use of samples to initiate therapy does not meet step edit/preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****