Jefferson Health Plans

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Ocaliva - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is this a renewal request?
If No, go to 4.

☐ Yes ☐ No

Q2. Have updated labs documenting liver function and lipid panel been attached?

☐ Yes ☐ No

Q3. Is there confirmation showing disease improvement while on therapy?

☐ Yes ☐ No

Q4. Does the patient have the diagnosis of primary biliary cholangitis (PBC) confirmed by two of the following: a positive antimitochondrial antibody test, elevated serum alkaline phosphatase level, liver biopsy, or ultrasound of the liver? Please attach documentation.

☐ Yes ☐ No

Q5. Has the patient been taking ursodeoxycholic acid (UDCA) for at least one year without response and will be continuing treatment with UDCA while on Ocaliva?

☐ Yes ☐ No

Q6. Is the patient unable to tolerate UDCA?

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☐ Yes ☐ No

Q7. Has the patient had recent liver function tests and lipid panel completed? Must attach lipid panel, AST/ALT, alkaline phosphatase, total bilirubin.

☐ Yes ☐ No

Q8. Will Ocaliva be prescribed by a hepatologist or gastroenterologist?

☐ Yes ☐ No

Q9. Does the patient have any of the following? A) Decompensated cirrhosis (e.g., Child-Pugh Class B or C) or a prior decompensation event. B) Compensated cirrhosis with evidence of portal hypertension. C) Complete biliary obstruction.

☐ Yes ☐ No

Q10. Requested Duration:

☐ 12 Months ☐ Other:

Q11. Additional Information:

_____ _____

Prescriber Signature Date

2024 Medicare Prior Authorization Request