Ocaliva (for Maryland only)

Prior Authorization Request

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

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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the diagnosis?
   ❑ Primary biliary cholangitis (PBC) (previously known as primary biliary cirrhosis)
   ❑ Other _____
2. What is the ICD-10 code? _____
3. Would the prescriber like to request an override of the step therapy requirement? ❑ Yes ❑ No *If No, skip to #6*
4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days?
   ❑ Yes ❑ No ***ACTION REQUIRED: Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)***
5. Is the medication effective in treating the member's condition? ❑ Yes ❑ No *Continue to #6 and complete this form in its entirety.*
6. Is the patient currently receiving Ocaliva? ❑ Yes ❑ No *If No, skip to #8*
7. Has the patient achieved at least a 15% reduction in alkaline phosphatase (ALP) level since starting therapy with Ocaliva? ❑ Yes ❑ No *No further questions*
8. Has the diagnosis been confirmed by at least two of the following?
   ❑ 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 or equal to 1:80 by immunofluorescence or M2 positivity by enzyme immunoassay) or PBC-specific antibodies (eg, anti-gp210, anti-sp100)
   ❑ Histologic evidence of PBC on liver biopsy (eg, nonsuppurative destructive cholangitis and destruction of interlobular bile ducts)
   ❑ Other _____

9. What was the patient's alkaline phosphatase (ALP) level prior to initiating therapy with Ocaliva?
   ❑ Greater than or equal to 1.5 times the upper limit of normal (ULN)
   ❑ Less than 1.5 times ULN

10. 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 #12*

11. Will the patient continue concomitant therapy with UDCA/ursodiol? ❑ Yes ❑ No *No further questions*

12. Did the patient experience intolerance to therapy with UDCA/ursodiol?
    ❑ Yes, ***please specify type of intolerance:*** _____ ❑ No

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)**