CVS caremark™ {{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.

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:** {{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}}

1. What is the diagnosis?
   ❑ Primary biliary cholangitis (PBC) (previously known as primary biliary cirrhosis)
   ❑ Other _____
2. What is the ICD-10 code? _____
3. Does the patient have decompensated cirrhosis (e.g., Child-Pugh Class B or C) or a prior decompensation event?
   ❑ Yes ❑ No
4. Does the member have compensated cirrhosis with evidence of portal hypertension (e.g., ascites, gastroesophageal varices, persistent thrombocytopenia)? ❑ Yes ❑ No
5. Is the patient currently receiving Ocaliva? ❑ Yes ❑ No *If No, skip to #7*
6. 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 current serum alkaline phosphatase (ALP) and/or current total bilirubin level(s).***
   ❑ Yes ❑ No *No further questions.*
7. Has the diagnosis of PBC been confirmed by at least two of the following three criteria? *Indicate ALL that apply.*
   ❑ Yes - Biochemical evidence of cholestasis with elevation of alkaline phosphatase (ALP) level for at least 6 months duration
   ❑ Yes - Presence of antimitochondrial antibodies (AMA) (titer greater than 1:40 by immunofluorescence or immunoenzymatic reactivity) or PBC-specific antinuclear antibodies (ANA) (e.g., anti-gp210, anti-sp100)
   ❑ Yes - Histologic evidence of PBC on liver biopsy (eg, non-suppurative inflammation and destruction of interlobular and septal bile ducts)
   ❑ No - None of the above
8. 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

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

9. 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 #11*
10. Will the patient continue concomitant therapy with UDCA/ursodiol? ❑ Yes ❑ No *No further questions.*
11. 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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