PriorityHealth

Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**

This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Ocaliva™ (obeticholic acid)

Member

Last Name: ______________________ First Name: ______________________

ID #: ______________________ DOB: ____________ Gender: ____________

Primary Care Physician: ______________________

Requesting Provider: ______________________ Prov. Phone: ____________ Prov. Fax: ____________

Provider Address: ______________________

Provider NPI: ______________________ Contact Name: ______________________

Provider Signature: ______________________ Date: ____________

Drug information

☐ New request ☐ Continuation request

Drug product: ☐ Ocaliva 5 mg tablet ☐ Ocaliva 10 mg tablet

Start date (or date of next dose): ____________

Date of last dose (if applicable): ____________

Dosing frequency: ____________

Precertification Requirements

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

For this drug to be covered, the patient must meet the following criteria:

1. Must be used for a medically-accepted indication*
2. Must have received 12 months of ursodiol therapy and have had an inadequate response or be intolerant to ursodiol
3. Must have one of the following:
    a. Alkaline phosphatase level ≥ 1.67 times the upper limit of normal; or
    b. Total bilirubin ≥ 1 times the upper limit of normal but < 2 times the upper limit of normal

Medically accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

All fields must be complete and legible for review. Your office will receive a response via fax.

No changes made since 09/2018
Last reviewed 09/2018

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Priority Health Precertification Documentation

1. **What condition is this drug being requested for?**
   - ☐ Primary biliary cholangitis
   - ☐ Other – rationale for use: ______________________________

2. **When did the patient begin ursodiol therapy?**

   Date: ______________________

3. **Will the patient use Ocaliva along with ursodiol?**
   - ☐ Yes
   - ☐ No

4. **Did the patient have an inadequate response to ursodiol?**
   - ☐ Yes
   - ☐ No

5. **Does the patient have intolerance to ursodiol?**
   - ☐ Yes
   - ☐ No

6. **Please provide one of the following (or send lab results to Priority Health):**

   Total bilirubin:____________**mg/dL; Testing Reference Range**:_______________**Date drawn**: ____________

   Alkaline phosphatase:__________**U/L**; **Testing Reference Range**:_________________**Date drawn**: _________

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Ocaliva likely be the most effective option for this patient?
☐ Yes ☐ No
If yes, please explain why: ______________________________

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If the patient is currently using Ocaliva, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ Yes ☐ No
If yes, please explain: ______________________________

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