



Cholestatic pruritis agents prior authorization of benefits form

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-474-3341.

1. Patient information

2. Physician information

Patient name: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient phone #: _____ Patient email address: _____	Prescribing physician: _____ Physician address: _____ Physician phone #: _____ Physician fax #: _____ Physician specialty: _____ Physician DEA: _____ Physician NPI #: _____ Physician email address: _____
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3. Medication

4. Strength

5. Directions

6. Quantity per 30 days

			Specify:
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7. Diagnosis:

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is this a renewal request?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the client have a diagnosis of progressive familial intrahepatic cholestasis (PFIC) confirmed with genetic testing?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the client have a diagnosis of PFIC type 2 with ABCB11 variants resulting in non-functional or complete absence of bile salt export pump protein (BSEP3)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the client have a history of liver transplant?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the client have a history of biliary diversion surgery in the last 180 days?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has the client had at least 90 days therapy in the last 180 days of a standard agent used for the treatment of cholestatic pruritis (for instance, Cholestyramine, Naltrexone, Prevalite, Questran, Rifampin, Sertraline, Urso, Urso Forte, Ursodiol, Zolofit)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the client have an ALT and total bilirubin that is less than (<) 10 times the upper limit of normal (ULN)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the client have a diagnosis of Alagille syndrome confirmed with genetic testing?

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Medicaid services provided by Wellpoint Insurance Company to members in the Medicaid Rural Service Area and the STAR Kids program and Wellpoint Texas, Inc. to all other Wellpoint members in Texas.

Yes No Will the client have concurrent therapy with another ileal bile acid transporter (IBAT) inhibitor?

For the *Medicaid Preferred Drug List*, please refer to the Medicaid Vendor Drug Program website at <https://www.txvendordrug.com/formulary/formulary-search>

9. Physician signature

Prescriber or authorized signature

Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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