

Health Partners 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: <input type="checkbox"/> 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.

<p>Q1. Is this a renewal request? If No, go to 4.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q2. Have updated labs documenting liver function and lipid panel been attached?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q3. Is there confirmation showing disease improvement while on therapy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Does the patient have the diagnosis of primary biliary cholangitis (PBC) confirmed by two of the following: a positive antimicrobial antibody test, elevated serum alkaline phosphatase level, liver biopsy, or ultrasound of the liver? Please attach documentation.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>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?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is the patient unable to tolerate UDCA?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Has the patient had recent liver function tests and lipid panel completed? Must attach lipid panel, AST/ALT, alkaline phosphatase, total bilirubin.</p>

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

Health Partners 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:
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Will Ocaliva be prescribed by a hepatologist or gastroenterologist? <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. Requested Duration: <input type="checkbox"/> 12 Months	
Q11. Additional Information:	

 Prescriber Signature

 Date

2023 Medicare Prior Authorization Request