pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

OCALIVA (obeticholic acid) PRIOR AUTHORIZATION FORM

- **Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request.**
- Prior authorization guidelines and quantity limits may be found in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapters – **Bile Salts** and **Quantity Limits/Daily Dose Limits** accessible on the Department's Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested: Ocaliva tablet	Strength:	Quantity:
Directions:		Refills:
Diagnosis:		Dx code *(required)*:

Specialty Pharmacy Drug Program: What Specialty Pharmacy will be used? ☐Diplomat Specialty ☐Walgreens Specialty

Initial Ocaliva requests	
1. If prescriber is NOT a hepatologist or gastroenterologist, is the requested medication being prescribed in consultation with one of the above specialists?	☐Yes – *Submit documentation of consultation.* ☐No or not applicable
2. Does the recipient have a diagnosis of primary biliary cholangitis (PBC)?	☐Yes – *Submit documentation of lab results and medical history supporting diagnosis.* ☐No – *Submit documentation supporting the use of Ocaliva for recipient's diagnosis.*
3. Does the Recipient have results of the following baseline (before starting Ocaliva) lab results? ☐AST ☐GGTP ☐bilirubin ☐HDL-C ☐ALT ☐alkaline phosphatase ☐INR	☐Yes – *Submit results and dates of all lab monitoring for all requested values.* ☐No
4. Does the recipient have a history of trial and failure, contraindication, or intolerance of ursodiol (ursodeoxycholic acid or UDCA)?	☐Yes – *Submit all supporting documentation of trial and failure (including doses tried), contraindications, or intolerances with ursodiol.* ☐No
5. Will the recipient be taking Ocaliva in combination with ursodiol?	☐Yes *Submit documentation of planned treatment regimen.* ☐No
Renewal Ocaliva requests	
6. Does the recipient have documentation of the following lab results since starting Ocaliva and within the past 6 months? ☐AST ☐GGT ☐bilirubin ☐HDL-C ☐ALT ☐alkaline phosphatase ☐INR	☐Yes – *Submit results and dates of all lab monitoring for all requested values.* ☐No
7. Has the Recipient shown clinical signs or symptoms or lab indicators of complete biliary obstruction since starting Ocaliva?	☐Yes *Submit documentation of clinical monitoring.* ☐No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: