

BILE SALTS PRIOR AUTHORIZATION FORM

To review the prior authorization guidelines for Bile Salts, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – Bile Salts (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA#: _____)	Prescriber name:	
<input type="checkbox"/> Renewal request	# of pages in request: _____		
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

Section A: All non-preferred requests			
Non-preferred medication requested <input type="checkbox"/> Chenodal <input type="checkbox"/> ursodiol capsule <input type="checkbox"/> ursodiol tablet			
(*Note: for Cholbam requests, go to Section B (initial requests) or Section C (renewal requests).. Cholbam is a preferred medication that requires clinical prior auth.)			
Strength:	Directions:	Quantity:	Refills:
Diagnosis:		DX code (required):	
1. Has the Recipient tried and failed, or have a contraindication or intolerance to, the preferred bile salts? Check all that apply.		<input type="checkbox"/> Yes – <u>submit all supporting documentation of drug regimen and treatment outcome</u>	
<input type="checkbox"/> Actigall capsule <input type="checkbox"/> Urso tablet <input type="checkbox"/> Urso Forte tablet		<input type="checkbox"/> No	
Section B: Initial Cholbam requests			
1. If prescriber is NOT a hepatologist or pediatric gastroenterologist, is the requested medication being prescribed in consultation with one of the above specialists?		<input type="checkbox"/> Yes – <u>submit documentation of consultation</u> <input type="checkbox"/> No or not applicable	
2. Does the Recipient have one of the following diagnoses?		<input type="checkbox"/> Yes – <u>submit results and dates of mass spectrometry or other biochemical or genetic testing</u>	
<input type="checkbox"/> bile acid synthesis disorder (BASD) due to a single enzyme defect (SED) <input type="checkbox"/> peroxisomal disorder (PD) (including Zellweger spectrum disorder)		<input type="checkbox"/> No – <u>submit documentation supporting the use of Cholbam for Recipient's diagnosis</u>	
3. <u>For a diagnosis of peroxisomal disorder</u> , will Cholbam be used in addition to other therapy/treatment?		<input type="checkbox"/> Yes – <u>submit documentation of concurrent therapy or treatment</u> <input type="checkbox"/> No	
3. Does the Recipient have results of the following baseline (before starting Cholbam) lab tests?		<input type="checkbox"/> Yes – <u>submit results and dates of all lab monitoring for all requested values</u> <input type="checkbox"/> No	
<input type="checkbox"/> AST <input type="checkbox"/> GGT <input type="checkbox"/> bilirubin <input type="checkbox"/> ALT <input type="checkbox"/> alkaline phosphatase <input type="checkbox"/> INR			
Section C: Renewal Cholbam requests			
1. Is the Recipient being monitored for all of the following lab values at a frequency indicated in the approved Cholbam package labeling (every month for the first 3 months of therapy, every 3 months for the next 9 months, every 6 months during the next 3 years, and annually thereafter)?		<input type="checkbox"/> Yes – <u>submit results and dates of all lab monitoring for all requested values</u> <input type="checkbox"/> No	
<input type="checkbox"/> AST <input type="checkbox"/> GGT <input type="checkbox"/> bilirubin <input type="checkbox"/> ALT <input type="checkbox"/> alkaline phosphatase <input type="checkbox"/> INR			
2. Has the Recipient shown clinical signs or symptoms or lab indicators of any of the following since starting Cholbam?		<input type="checkbox"/> Yes <u>Submit medical record documentation of clinical monitoring</u> <input type="checkbox"/> No	
<input type="checkbox"/> complete biliary obstruction <input type="checkbox"/> persistent or ongoing worsening of liver function <input type="checkbox"/> persistent or ongoing cholestasis			
3. <u>For the first renewal request after starting or restarting Cholbam</u> , has the Recipient experienced an improvement in liver function within the first 3 months of treatment?		<input type="checkbox"/> Yes – <u>submit results and dates of baseline LFTs and LFTs drawn 3 months after starting/restarting Cholbam</u> <input type="checkbox"/> No	

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

Prescriber Signature:	Date:
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