Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Ocaliva (obeticholic acid) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Ocaliva (obeticholic acid).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: http://pithelp.appl.kp.org/MAS/formulary.html**

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Is the prescriber a gastroenterologist or hepatologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Provider Name: _____ Specialty: _____ NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Please check the boxes that apply:
□ Initial Request □ Continuation of Therapy Request

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Member has a diagnosis of primary biliary cholangitis (PBC)? **AND**
   □ No □ Yes

2. Member has had an inadequate response to an adequate trial of ursodeoxycholic acid (UDCA) unless contraindication, **AND**
   □ No □ Yes

3. Member is taking an optimal regimen of cholesterol treatment (fenofibrate or statin) if most recent LDL >190 mg/dL, **AND**
   □ No □ Yes

4. Member has no history of severe pruritis, **AND**
   □ No □ Yes

5. There is absence of complete biliary obstruction, **AND**
   □ No □ Yes

6. Member is not listed/scheduled for liver transplant
   □ No □ Yes

Continuation of Therapy:

1. Member has a documentation of laboratory values showing a reduction in ALP level from pre-treatment baseline while on Ocaliva therapy?
   □ No □ Yes

6 – Provider Sign-Off

Additional Information – If response is "no" to any of the above, please provide/attach additional supporting information that should be taken into consideration:

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**