Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Relyvrio (sodium phenylbutyrate-taurursodiol) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 3 months; Continuation- 6 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Relyvrio (sodium phenylbutyrate-taurursodiol).** 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 all sections are complete.

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

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

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

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. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Prescriber is a Neurologist,
   □ No □ Yes
2. **AND** clinical ALS diagnosed by a neurologist with duration of 18 months or less from onset for first symptom,
   □ No □ Yes
3. **AND** forced vital capacity (%FVC) > 60%,
   □ No □ Yes
4. **AND** patient has had a trial of riluzole,
   □ No □ Yes
5. **AND** patient does not have a tracheostomy
   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Documentation of positive clinical response,
   □ No □ Yes
2. **AND** Neurologist follow-up occurred since last review,
   □ No □ Yes
3. **AND** patient does not have any of the following:
   - %FVC ≤ 50% and blood gas $PaCO_2$ >45 mmHg
   - Patient is requiring a tracheotomy or non-invasive ventilation all day
   - Significant clinical decline based on ALSFRS-R and/or %FVC status
   - Non-adherence to follow-up assessments
   - Patient is requiring hospice care

   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

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

Prescriber Signature:	**Date:**