HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Hepatic and Biliary Agents (formerly Bile Salts)

Phone: 215-991-4300 **Fax back to: 866-240-3712**

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.

Member Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. The request is for a Hepatic and Biliary Agent that was previously approved. If YES, go to 9.

☐ Yes ☐ No

Q2. The member is prescribed the Hepatic and Biliary Agent for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication.

☐ Yes ☐ No

Q3. The member is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q4. The member does not have a contraindication to the requested drug.

☐ Yes ☐ No

Q5. What type of drug is being requested?

☐ For cholic acid, go to 6.

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Member Name:	Prescriber Name:

☐ For a PPAR agonist, go to 7.
☐ For all other non-preferred Hepatic and Biliary Agents, Topical, go to 8.

Q6. For cholic acid, both of the following:

☐ Is prescribed cholic acid by or in consultation with a hepatologist or pediatric gastroenterologist

☐ Has documentation of a medical history and lab test results that support the beneficiary's diagnosis

Q7. For a PPAR agonist Hepatic and Biliary Agent, both of the following:

☐ Is prescribed the requested drug by or in consultation with a hepatologist or gastroenterologist

☐ Has documentation of a medical history and lab test results that support the beneficiary's diagnosis

Q8. For all other non-preferred Hepatic and Biliary Agents, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Hepatic and Biliary Agents approved or medically accepted for the beneficiary's diagnosis.

☐ Yes ☐ No

Q9. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q10. Does not have a contraindication to the requested drug.

☐ Yes ☐ No

Q11. What type of drug is being requested?

☐ For cholic acid, go to 12.
☐ For a PPAR agonist, go to 13.
☐ For all other non-preferred Hepatic and Biliary Agents, Topical, go to 14.

Q12. For cholic acid, all of the following:

☐ Is prescribed cholic acid by or in consultation with a hepatologist or pediatric gastroenterologist

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☐ Has documented improvement in liver function within the first 3 months of treatment

☐ Does not have complete biliary obstruction, persistent clinical or laboratory indicators of worsening liver function, or cholestasis.

Q13. For a PPAR agonist Hepatic and Biliary Agent, both of the following:

☐ Is prescribed the requested drug by or in consultation with a hepatologist or gastroenterologist

☐ Has documentation of a positive response to the requested drug as evidenced by liver function tests

Q14. For all other non-preferred Hepatic and Biliary Agents, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Hepatic and Biliary Agents approved or medically accepted for the beneficiary's diagnosis.

☐ Yes ☐ No

Q15. Additional Information:

Prescriber Signature

Date

v2026