Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

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.

Patient Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient 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. Is the request for a non-preferred bile salt?

☐ Yes ☐ No

Q2. Is this request for Ocaliva?

☐ Yes ☐ No

Q3. Does the patient have a history of therapeutic failure, contraindication or intolerance to the preferred bile salts (i.e., Cholbam, ursodiol)?

☐ Yes ☐ No

Q4. Is this request for Cholbam?

☐ Yes ☐ No

Q5. Is this request for continuation of therapy with Ocaliva?

☐ Yes ☐ No

Q6. Does the patient have a documented monitoring of liver function tests, including AST, ALT, GGT, alkaline phosphatase, bilirubin, and INR, since starting Ocaliva and within the past 6 months?

☐ Yes ☐ No

Q7. Does the patient have a documented positive response to Ocaliva as evidenced by liver function tests?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q8. Does the patient have recent HDL-C monitoring?

☐ Yes ☐ No

Q9. Does the patient have complete biliary obstruction?

☐ Yes ☐ No

Q10. Does the patient have a history of therapeutic failure, contraindication or intolerance to the preferred bile salts (i.e., Cholbam, ursodiol)?

☐ Yes ☐ No

Q11. Is Ocaliva prescribed by or in consultation with a hepatologist or gastroenterologist?

☐ Yes ☐ No

Q12. Is the patient being treated for a diagnosis that is indicated in the U. S. Food and Drug Administration (FDA)-approved package insert OR a medically accepted indication?

☐ Yes ☐ No

Q13. Is the diagnosis documented by medical history and laboratory results?

☐ Yes ☐ No

Q14. Does the patient have documented baseline liver function tests, including AST, ALT, GGT, alkaline phosphatase, bilirubin, and INR?

☐ Yes ☐ No

Q15. Does the patient have a documented baseline HDL-C?

☐ Yes ☐ No

Q16. Does the patient have a documented history of therapeutic failure of optimally-titrated doses of ursodeoxycholic acid (UDCA)?

☐ Yes ☐ No

Q17. Will Ocaliva be prescribed in combination with ursodeoxycholic acid (UDCA)?

☐ Yes ☐ No

Q18. Does the patient have a contraindication or intolerance to ursodeoxycholic acid (UDCA)?

☐ Yes ☐ No

Q19. Is this request for continuation of therapy with Cholbam?

☐ Yes ☐ No

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Q20. Does the patient have documented improvement in liver function within the first 3 months of treatment?

☐ Yes ☐ No

Q21. Does the patient have documented AST, ALT, GGT, alkaline phosphatase, bilirubin and INR monitoring as recommended per prescribing information?

☐ Yes ☐ No

Q22. Does the patient have complete biliary obstruction, persistent clinical or laboratory indicators of worsening liver function or cholestasis?

☐ Yes ☐ No

Q23. Is Cholbam prescribed by or in consultation with a hepatologist or gastroenterologist?

☐ Yes ☐ No

Q24. Is the patient being treated for a condition that is indicated in the U.S. Food and Drug Administration (FDA)-approved package insert or a medically accepted indication?

☐ Yes ☐ No

Q25. Is the condition documented by medical history and laboratory results?

☐ Yes ☐ No

Q26. Will the patient's AST, ALT, GGT, alkaline phosphatase, bilirubin and INR be monitored according to the prescribing information?

☐ Yes ☐ No

Prescriber Signature _____ Date _____

Updated for 2020

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