OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Ocaliva® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Primary biliary cholangitis (also known as primary biliary cirrhosis)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Has the patient failed to achieve an alkaline phosphatase (ALP) level less than 1.67 times the upper limit of normal (ULN) after at least 12 consecutive months of treatment with ursodeoxycholic acid (UDCA) (e.g., Urso, Urso Forte, ursodiol)? ❑ **Yes** ❑ **No**
Will Ocaliva be used in combination with ursodeoxycholic acid (UDCA)? ❑ **Yes** ❑ **No**
Is Ocaliva prescribed by or in consultation with a hepatologist or gastroenterologist? ❑ **Yes** ❑ **No**
Does the patient have moderate to severe hepatic impairment (Child-Pugh class B or C)? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had a reduction in ALP level from pre-treatment baseline (i.e., prior Ocaliva therapy) while on Ocaliva therapy?* ❑ **Yes** ❑ **No**
**Please note: Chart documentation of the above is required to be submitted along with this fax.*
Does the patient have moderate to severe hepatic impairment (Child-Pugh class B or C)? ❑ **Yes** ❑ **No**

Quantity Limit Requests:

What is the quantity requested per DAY? _____
What is the reason for exceeding the plan limitations?
❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Ocaliva_Comm_2018Jun-W