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 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

Q2. Is the patient prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-review medical literature?

☐ Yes ☐ No

Q3. Does the patient have a contraindication to the requested medication?

☐ Yes ☐ No

Q4. Is this request for cholic acid (Cholbam)?

☐ Yes ☐ No

Q5. Is cholic acid prescribed by or in consultation with a hepatologist or pediatric gastroenterologist?

☐ Yes ☐ No

Q6. Is the condition documented by medical history and laboratory results?

☐ Yes ☐ No

Q7. Is this request for obeticholic acid (Ocaliva)?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q8. Is obeticholic acid (Ocaliva) prescribed by or in consultation with a hepatologist or gastroenterologist?

☐ Yes ☐ No

Q9. Is the condition documented by medical history and laboratory results?

☐ Yes ☐ No

Q10. Does the patient have a documented history of therapeutic failure of optimally-titrated doses of ursodeoxycholic acid (UDCA)?

☐ Yes ☐ No

Q11. Will obeticholic acid be prescribed in combination with ursodeoxycholic acid (UDCA) OR does the patient have a contraindication or intolerance to ursodeoxycholic acid (UDCA)?

☐ Yes ☐ No

Q12. Is the request for a non-preferred bile salt?

☐ Yes ☐ No

Q13. Does the patient have a history of therapeutic failure, contraindication, or intolerance to the preferred bile salts (i.e., Cholbam (cholic acid), ursodiol)?

☐ Yes ☐ No

Q14. Is this request for continuation of therapy with cholic acid and prescribed by or in consultation with a hepatologist or pediatric gastroenterologist?

☐ Yes ☐ No

Q15. Does the patient have documented improvement in liver function within the first 3 months of treatment with cholic acid?

☐ Yes ☐ No

Q16. Does the patient have complete biliary obstruction, persistent clinical or laboratory indicators of worsening liver function or cholestasis?

☐ Yes ☐ No

Q17. Is this request for continuation of therapy with obeticholic acid (Ocaliva) and prescribed by or in consultation with a hepatologist or gastroenterologist?

☐ Yes ☐ No

Q18. Does the patient have a documented positive response to obeticholic acid as evidenced by liver function tests?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q19. Additional Information:

_____ _____

Prescriber Signature Date

Updated for 2023