



Bylvay (odevixibat)
Prior Authorization Request Form



Caterpillar Prescription Drug Benefit
 Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

URGENT

MEMBER INFORMATION	
LAST NAME:	FIRST NAME:
PHONE NUMBER:	DATE OF BIRTH:
STREET ADDRESS:	
CITY:	STATE: ZIP CODE:
PATIENT INSURANCE ID NUMBER:	

MALE **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF](https://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	FIRST NAME:
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:
NPI NUMBER:	DEA NUMBER:
PHONE NUMBER:	FAX NUMBER:
STREET ADDRESS:	
CITY:	STATE: ZIP CODE:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.





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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? YES (if yes, complete below) NO

MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:

2. LIST DIAGNOSES: **ICD-10:**

<input type="checkbox"/> Progressive familial intrahepatic cholestasis(PFIC) <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____	
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3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Is the drug going to be used in conjunction with a clinical trial? Yes No

Is prescriber a gastroenterologist, hepatologist, or dermatologist? Yes No

Does patient have a diagnosis of progressive familial intrahepatic cholestasis (PFIC) Type I or II? Yes No *Please submit genetic confirmation*

If Type II, is Type II ASCBII or BSEP-3? Yes No *Please submit genetic confirmation.*

Does patient have a history of significant pruritis? Yes No

Does patient have elevated serum bile acid(s-BA) concentrations greater than 3 times the upper limit of normal for their age? Yes No *Please submit lab report.*

Does patient have a past medical history or ongoing presence of other types of liver disease including, but not limited to the following? Yes No

- Biliary atresia of any kind?
- Benign recurrent intrahepatic cholestasis?
- Suspected or proven liver cancer or metastasis to the liver?
- Histopathology on liver biopsy that is suggestive of alternate non-PFIC related etiology of cholestasis?

Does patient have suspected or confirmed cancers outside basal cell carcinoma prior to treatment with Bylvay(odevixibat) with no evidence of recurrence? Yes No

Has patient had biliary diversion surgery within last 6months of starting Bylvay(odevixibat) ? Yes No

Has patient had a liver transplant or is a liver transplant planned within 6months of starting Bylvay(odevixibat)?

Does patient have decompensated liver disease? Yes No

Is patient's pruritis caused by another condition outside PFIC? Yes No

Has the patient been previously treated with Livmarli(maralixibat) or another IBAT inhibitor? Yes No

If previously treated with Livmarli(maralixibat) or another IBAT inhibitor, was patient's pruritis responsive? Yes No

If patient is 12 years of age to 17 years of age inclusive, has patient failed an adequate trial of cholestyramine? Yes No *Please provide documentation.*

Is patient intolerant to or has an absolute contraindication to cholestyramine? Yes No *Please provide documentation.*





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If patient is 18 years of age or older, has failed an adequate trial to at least 1 pruritus treatment (e.g., ursodeoxycholic acid [ursodiol], cholestyramine, rifampin, naloxone, naltrexone)? Yes No *Please provide documentation.*

Is patient intolerant to, or has an absolute contraindication to at least 1 pruritus treatment (e.g., ursodeoxycholic acid [ursodiol], cholestyramine, rifampin, naloxone, naltrexone)? Yes No *Please provide documentation.*

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:** Not all drugs/diagnoses are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program

Attn: CP - 4201

P.O. Box 64811

St. Paul, MN 55164-0811

