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

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:**
☐ **NEW THERAPY** ☐ **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:**
☐ Progressive familial intrahepatic cholestasis(PFIC) ☐ Other diagnosis: _____ICD-10_____	

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?

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.*

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.*

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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:** _____

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

Last Updated: 7/15/2023