UnitedHealthcare Community Plan

Ocaliva
PRIOR AUTHORIZATION REQUEST FORM

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: _____
Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Physician Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs
Please refer to www.uhccommunityplan.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

- Does the patient have a diagnosis of primary biliary cholangitis (aka primary biliary cirrhosis)? □ Yes □ No

- Has the patient failed to achieve an alkaline phosphatase (ALP) level of less than 1.67 times the upper limit of normal after at least 12 consecutive months of treatment with ursodeoxycholic acid (e.g. Urso, ursodiol)?
□ Yes □ No

- Will Ocaliva be used in combination with ursodeoxycholic acid (e.g. Urso, ursodiol)? □ Yes □ No

- Does the patient have a history of contraindication or intolerance to ursodeoxycholic acid (e.g. Urso, ursodiol)?
□ Yes □ No
(If yes, complete Section D above with medication information, including dose, duration, and date of trial)

- Is Ocaliva prescribed by one of the following? □ Yes □ No (check which apply)
□ Hepatologist □ Gastroenterologist

Requests for Continuation of Therapy:

- Does the patient have documented medical records (e.g., laboratory values) showing a reduction in ALP level from pre-treatment baseline (i.e., prior to Ocaliva therapy) while on Ocaliva therapy? □ Yes □ No

Physician Signature: _____ Date: _____