Ileal Bile Acid Transporter Inhibitors Prior Authorization of Benefits Form

Contains confidential patient information

Complete form and fax to: Prior authorization of benefits center at **844-474-3341**.

1. Patient information

Patient name: _____

Patient ID: _____

Patient DOB: _____

Date of Rx: _____

Patient phone _____

Patient email address: _____

2. Physician information

Prescribing physician: _____

Physician address: _____

Physician phone: _____

Physician fax: _____

Physician specialty: _____

Physician DEA: _____

Physician NPI: _____

Physician email address: _____

3. Medication	4. Strength	5. Directions	6. Quantity per [30 days]
			Specify:

7. Diagnosis:

8. Approval criteria: Mark all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.

- ☐ Yes ☐ No Is this a renewal request?
- ☐ Yes ☐ No Does the client have a diagnosis of progressive familial intrahepatic cholestasis (PFIC) confirmed with genetic testing?
- ☐ Yes ☐ No Does the client have a diagnosis of PFIC type 2 with ABCB11 variants resulting in non-functional or complete absence of bile salt export pump protein (BSEP3)?
- ☐ Yes ☐ No Does the client have a history of liver transplant?
- ☐ Yes ☐ No Does the client have a history of biliary diversion surgery in the last [180 days]?
- ☐ Yes ☐ No Has the client had at least [90 days] therapy in the last [180 day]s of a standard agent used for the treatment of cholestatic pruritis (for instance, Cholestyramine, Naltrexone, Prevalite, Questran, Rifampin, Sertraline, Urso, Urso Forte, Ursodiol, Zoloft)?

☐ Yes ☐ No	Does the client have an ALT and total bilirubin that is less than [10 times] the upper limit of normal (ULN)?
☐ Yes ☐ No	Does the client have a diagnosis of Alagille syndrome confirmed with genetic testing?
☐ Yes ☐ No	Will the client have concurrent therapy with another ileal bile acid transporter (IBAT) inhibitor?

For the *Medicaid Preferred Drug List*, please refer to the Medicaid Vendor Drug Program website at [**txvendordrug.com/formulary/formulary-search**].

9. Physician signature

_____	_____
Prescriber or authorized signature	Date

Prior authorization of benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.