PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS

Livmarli - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Livmarli - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Livmarli (maralixibat)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

[If no, skip to question 6.]

2.	Is there documentation showing the patient is tolerating treatment?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
3.	Is there documentation of one of the following: A) Decrease in pruritis from baseline, or B) Decrease in serum bile acid concentration?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
4.	Does the patient have any of the following exclusions to therapy: A) Patient is a pediatric patient less than 3 months of age, B) Dose exceeds 380 mcg/kg per day and daily dose volumes are greater than 3 mL or 28.5 mg per day, or C) Patient has cirrhosis or portal hypertension?	Y N
	[If yes, no further questions.]	
5.	Will the requested medication be used for an indication or use that is not Food and Drug Administration (FDA)-approved or guideline-supported?	Y N
	[No further questions.]	
6.	Does the patient have a documented diagnosis of Alagille syndrome (ALGS), confirmed with genetic testing showing a JAG1 or NOTCH2 mutation?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
7.	Has documentation been submitted showing the patient has significant moderate-to-severe pruritis?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
8.	Has documentation been submitted showing evidence of cholestasis, as shown by at least one of the following: A) Total serum bile acid greater than 3 times upper limit of normal (ULN) for age, B) Conjugated bilirubin greater than 1 mg/dL, C) Fat-soluble vitamin deficiency otherwise unexplainable, D) Gamma-glutamyl transferase greater than 3 times ULN for age, or E) Intractable pruritis explainable only by liver disease?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
9.	Has documentation been submitted showing patient has had a trial and inadequate response, or contraindication to, BOTH of the following: A) ursodiol (ursodeoxycholic acid), AND B) an agent used for symptomatic relief of pruritis (e.g., cholestyramine, rifampin)?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	

10. Has documentation been submitted showing the prescriber is, or has consulted with, a hepatologist or gastroenterologist with experience in managing Alagille syndrome (ALGS)?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
11. Is the patient 3 months of age or older?	Y N	
[If no, no further questions.]		
12. Does the patient have either of the following exclusions to therapy: A) Dose exceeds 380 mcg/kg per day and daily dose volumes are greater than 3 mL or 28.5 mg per day, or B) Patient has cirrhosis or portal hypertension?	Y N	
[If yes, no further questions.]		
13. Will the requested medication be used for any indication or use that is not Food and Drug Administration (FDA)-approved or guideline-supported?	Y N	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date