

<b>Prior Authorization</b>
<b>JOHNS HOPKINS HEALTH PLANS (MEDICAID)</b> Ocaliva - 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 <b>1-410-424-4607</b> . Please contact Johns Hopkins Health Plans at <b>1-888-819-1043</b> with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Ocaliva - Priority Partners MCO.

Drug Name (select from list of drugs shown) Ocaliva (obeticholic acid)
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Quantity	Frequency	Strength
Route of Administration	Expected Length of Therapy	

<b>Patient Information</b>	
Patient Name:	_____
Patient ID:	_____
Patient Group No.:	_____
Patient DOB:	_____
Patient Phone:	_____

<b>Prescribing Physician</b>	
Physician Name:	_____
Physician Phone:	_____
Physician Fax:	_____
Physician Address:	_____
City, State, Zip:	_____

<b>Diagnosis:</b> _____	<b>ICD Code:</b> _____
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Comments: _____
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<b>Please circle the appropriate answer for each question.</b>	
1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?	<input type="checkbox"/> Y <input type="checkbox"/> 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 yes, skip to question 6.]	

2. Does the patient have a documented diagnosis of primary biliary cholangitis (PBC)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
3. Is the requested medication being used in conjunction with ursodeoxycholic acid (UDCA)	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 5]	
4. If the requested medication is being used as monotherapy, has the patient had a documented inadequate response to ursodeoxycholic acid?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
5. Is the patient 18 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
6. Is there documentation demonstrating clinical benefit from treatment?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	

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.

<b>Prescriber (Or Authorized) Signature and Date</b>