TRICARE Prior Authorization Request Form for odevixibat (Bylvay)



7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

| To be completed by Requesting provider | | |
|--|----------------------|--|
| Drug Name: | Strength: | |
| | | |
| Dosage/Frequency (SIG): | Duration of Therapy: | |
| | | |

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

| Please complete patient and physician information (please print): | | | | | | |
|---|--|--|--|----------------------------|--|--|
| 1 | Patient | Name: Phys | sician Name: | | | |
| | Addres | s: | Address: | | | |
| | Sponso | | Phone #: | | | |
| | Date of | | ecure Fax #: | | | |
| Step | Please complete the clinical assessment: | | | | | |
| 2 | 1. | Has the patient received this medication under the TRICARE benefit in the last 6 months? Please choose "No" if the patient did not previously have a TRICARE approved PA for Bylvay. | ☐ Yes (subject to verification) Proceed to question | □ No Proceed to question 2 | | |
| | 2. | Is the requested medication prescribed by a pediatric gastroenterologist, or pediatric hepatology transplant specialist? | ☐ Yes Proceed to question | | | |
| | | | | Coverage not approved | | |
| | 3. | Is the patient greater than or equal to 3 months of | ☐ Yes | □ No | | |
| | | age AND greater than or equal to 5 kg? | Proceed to question | \$ STOP | | |
| | | | | Coverage not approved | | |
| | 4. | | ☐ Yes | □ No | | |
| | | the patient has a diagnosis of progressive familial intrahepatic cholestasis (PFIC) with severe | Proceed to question | STOP | | |
| | | refractory pruritus? | | Coverage not approved | | |
| | | Non-FDA indications such as NASH, PFIC2, Alagille syndrome, Biliary atresia are NOT approved. | | | | |
| | | PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. | | | | |
| | 5. | Has the patient been evaluated for possible | ☐ Yes | □No | | |
| | | orthotopic liver transplant (OLT)? | Proceed to question | STOP | | |
| | | | | Coverage not approved | | |

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| medication or contraindication to each medication listed below must be provided or your case could be denied. 7. Please provide the date of trial and response to treatment for each medication below: Drug | | 6. Has the patient tried and failed or had intolerance to ALL of the following: ursodiol, cholestyramine, rifampin, naltrexone, antihistamine (for example, hydroxyzine, diphenhydramine)? Note: The dates and durations of therapy for each | | ☐ Yes Proceed to question 7 | | □ No STOP Coverage not approved | | |
|--|-----|---|---|--|-----------|---------------------------------|----------------------|--------------|
| Drug Date of Trial Response to therapy Ursodiol Cholestyramine Rifampin Naltrexone Antihistamine (for example hydroxyzine, diphenhydramine) Note: The dates and durations of therapy for each medication or contraindication to each medication listed below see provided or your case could be denied. Sign and date below 8. Has documentation been submitted to confirm that the patient has demonstrated significant improvement in pruritus symptoms? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. 9. Will Bylvay be discontinued if the patient undergoes liver transplant? Prescriber Signature Date | | | medication or contraindication t listed below must be provided of | o each medication | | | | |
| Ursodiol Cholestyramine Rifampin Naltrexone Antihistamine (for example hydroxyzine, diphenhydramine) Note: The dates and durations of therapy for each medication or contraindication to each medication listed below reprovided or your case could be denied. Sign and date below 8. Has documentation been submitted to confirm that the patient has demonstrated significant improvement in pruritus symptoms? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. 9. Will Bylvay be discontinued if the patient undergoes liver transplant? Sign and date below Sign and date below Top Coverage not apping the patient will be above is true to the best of my knowledge. Please sign and date: | | 7. | Please provide the date of tria | al and response to trea | tment for | each medication | below: | |
| Cholestyramine Rifampin Naltrexone Antihistamine (for example hydroxyzine, diphenhydramine) Note: The dates and durations of therapy for each medication or contraindication to each medication listed below see provided or your case could be denied. Sign and date below 8. Has documentation been submitted to confirm that the patient has demonstrated significant improvement in pruritus symptoms? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. 9. Will Bylvay be discontinued if the patient undergoes liver transplant? Prescriber Signature Date Prescriber Signature Date | | | Drug | Date of Trial | | Response to th | erapy | |
| Rifampin Naltrexone Antihistamine (for example hydroxyzine, diphenhydramine) Note: The dates and durations of therapy for each medication or contraindication to each medication listed below see provided or your case could be denied. Sign and date below 8. Has documentation been submitted to confirm that the patient has demonstrated significant improvement in pruritus symptoms? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. 9. Will Bylvay be discontinued if the patient undergoes liver transplant? Prescriber Signature Date | | | Ursodiol | | | | | |
| Naltrexone Antihistamine (for example hydroxyzine, diphenhydramine) Note: The dates and durations of therapy for each medication or contraindication to each medication listed below reprovided or your case could be denied. Sign and date below 8. Has documentation been submitted to confirm that the patient has demonstrated significant improvement in pruritus symptoms? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. 9. Will Bylvay be discontinued if the patient undergoes liver transplant? Sign and date below STOP Coverage not approved the patient of the patient | | | Cholestyramine | | | | | _ |
| Antihistamine (for example hydroxyzine, diphenhydramine) Note: The dates and durations of therapy for each medication or contraindication to each medication listed below reprovided or your case could be denied. Sign and date below 8. Has documentation been submitted to confirm that the patient has demonstrated significant improvement in pruritus symptoms? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. 9. Will Bylvay be discontinued if the patient undergoes liver transplant? Sign and date below STOP Coverage not apple of the patient of the pati | | | Rifampin | | | | | |
| Note: The dates and durations of therapy for each medication or contraindication to each medication listed below reprovided or your case could be denied. Sign and date below | | | Naltrexone | | | | | |
| Sign and date below 8. Has documentation been submitted to confirm that the patient has demonstrated significant improvement in pruritus symptoms? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. 9. Will Bylvay be discontinued if the patient undergoes liver transplant? Prescriber Signature Sign and date below Proceed to question 9 Coverage not apple of the patient process of the patient of the patient process of the patient of the patient of the patient process of the patient of the pati | | | example hydroxyzine, | | | | | |
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| the patient has demonstrated significant improvement in pruritus symptoms? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. 9. Will Bylvay be discontinued if the patient undergoes liver transplant? Prescriber Signature Proceed to question 9 Coverage not appropriate to your request could be denied. Prescriber Signature Proceed to question 9 Coverage not appropriate to your response to this question must be attached to this case or your request could be denied. Prescriber Signature Proceed to question 9 Coverage not appropriate to your response to this question appropriate to your response to your request could be denied. Prescriber Signature Proceed to question appropriate to your response to your request could be denied. | | | Has documentation been sub | | | | □ No | |
| response to this question must be attached to this case or your request could be denied. 9. Will Bylvay be discontinued if the patient undergoes liver transplant? Sign and date below Coverage not appropriate the above is true to the best of my knowledge. Please sign and date: Prescriber Signature Date | | ٥. | the patient has demonstrated significant | | | | | |
| I certify the above is true to the best of my knowledge. Please sign and date: Prescriber Signature Date Sign and date below STOP Coverage not appropriate to the best of my knowledge. Please sign and date: | | | improvement in pruritus sym | ptoms? | 1 | | Coverage not approve | |
| I certify the above is true to the best of my knowledge. Please sign and date: Prescriber Signature Date Sign and date below Coverage not approached. Date | | | PLEASE NOTE: Medical documer response to this question must be | ntation specific to your | | | Coverage | not approve |
| I certify the above is true to the best of my knowledge. Please sign and date: Prescriber Signature Date | | 9. | PLEASE NOTE: Medical documer response to this question must be or your request could be denied. Will Bylvay be discontinued if | ntation specific to your e attached to this case | | □ Yes | | |
| Prescriber Signature Date | | 9. | PLEASE NOTE: Medical documer response to this question must be or your request could be denied. Will Bylvay be discontinued if | ntation specific to your e attached to this case | | | | ⊐ No |
| · · · · · · · · · · · · · · · · · · · | | | PLEASE NOTE: Medical documer response to this question must be or your request could be denied. Will Bylvay be discontinued if undergoes liver transplant? | ntation specific to your e attached to this case f the patient | Sign a | nd date below | l S Coverage | ⊐ No STOP |
| [24 December | I c | | PLEASE NOTE: Medical documer response to this question must be or your request could be denied. Will Bylvay be discontinued if undergoes liver transplant? | ntation specific to your e attached to this case f the patient | Sign a | nd date below | l S Coverage | ⊐ No STOP |
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| For Internal Use Only | | | |
|-----------------------|-------------------------------|--|--|
| Approved: | Duration of Approval:month(s) | | |
| ☐ Denied: | Authorized By: | | |
| ☐ Incomplete/Other: | PA#: | | |
| Date Faxed to MD: | Date Decision Rendered: | | |