TRICARE Prior Authorization Request Form for
odevixibat **(Bylvay)**

JOHNS HOPKINS
HEALTH PLANS

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.

Initial therapy approves for 6 months.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

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 8**	☐ No **Proceed to question 2**
2. Is the requested medication prescribed by a pediatric gastroenterologist, or pediatric hepatology transplant specialist?	☐ Yes **Proceed to question 3**	☐ No **STOP Coverage not approved**
3. Is the patient greater than or equal to 3 months of age AND greater than or equal to 5 kg?	☐ Yes **Proceed to question 4**	☐ No **STOP Coverage not approved**
4. Has documentation been submitted to confirm that the patient has a diagnosis of progressive familial intrahepatic cholestasis (PFIC) with severe refractory pruritus? 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.**	☐ Yes **Proceed to question 5**	☐ No **STOP Coverage not approved**
5. Has the patient been evaluated for possible orthotopic liver transplant (OLT)?	☐ Yes **Proceed to question 6**	☐ No **STOP Coverage not approved**

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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 medication or contraindication to each medication listed below must be provided or your case could be denied.	☐ Yes **Proceed to question 7**	☐ No **STOP** **Coverage not approved**

7. Please provide the date of trial and response to treatment for each medication below:

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 must be 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.**	☐ Yes **Proceed to question 9**	☐ No **STOP** **Coverage not approved**
9. Will Bylvay be discontinued if the patient undergoes liver transplant?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[24 December 2021]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: