

TRICARE Prior Authorization Request Form for
elafibranor (**Iqirvo**)



JOHNS HOPKINS
HEALTH PLANS

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

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

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

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

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

Prior authorization of initial therapy is 1 year. For renewal of therapy an initial Tricare prior authorization approval is required.

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:

3.	1. Has the patient received this medication under the TRICARE benefit in the last 6 months? <i>Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.</i>	<input type="checkbox"/> Yes (subject to verification) Proceed to question 11	<input type="checkbox"/> No Proceed to question 2
	2. Is the patient greater than or equal to 18 years of age?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
	3. Does the patient have a diagnosis of primary biliary cholangitis (PBC)?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
	4. Has the diagnosis of primary biliary cholangitis (PBC) been confirmed by at least TWO of the following: alkaline phosphatase (ALP) elevated above the upper limit of normal (ULN) as defined by normal laboratory reference values; positive anti-mitochondrial antibodies (AMAs); histologic evidence of PBC from a liver biopsy?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
	5. Is the requested medication prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No STOP Coverage not approved
	6. Has the patient been receiving ursodiol therapy (for example, ursodiol generics, Urso 250, Urso Forte, Actigall) for one year or greater and has had an inadequate response?	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No Proceed to question 7

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7. Is the patient unable to tolerate ursodiol therapy?	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No STOP Coverage not approved
8. Does the patient have a contraindication to obeticholic acid (Ocaliva)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 9
9. Does the patient have an intolerability to obeticholic acid (Ocaliva)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 10
10. Has the patient failed a trial of obeticholic acid (Ocaliva)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
11. Has the patient responded to the requested medication as determined by the prescribing physician (for example, improved biochemical markers of PBC [alkaline phosphatase (ALP), bilirubin, gamma-glutamyl transpeptidase (GGT), aspartate aminotransferase (AST), alanine aminotransferase (ALT) levels)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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

[13 November 2024]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: