TRICARE Prior Authorization Request Form for
seladelpar (Livdelzi)

JOHNS HOPKINS
HEALTH PLANS

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

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

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 prior authorization expires after 6 months, renewal criteria is approved indefinite. 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:**

Question		
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 the requested medication.*	☐ Yes (subject to verification) Proceed to question **10**	☐ No **Proceed to question 2**
2. Is the patient 18 years of age or older?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the requested medication prescribed by a gastroenterologist, hepatologist, or liver transplant physician?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. What is the indication or diagnosis?	☐ Primary biliary cholangitis (PBC) - Proceed to question **5** ☐ Other diagnosis – **STOP – Coverage not approved**	
5. Has the diagnosis been confirmed by at least TWO of the following: (a) alkaline phosphatase (ALP) elevated above the upper limit of normal (ULN) as defined by normal laboratory reference values, (b) positive anti-mitochondrial antibodies (AMAs), and (c) histologic evidence of PBC from a liver biopsy?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Does the patient have decompensated cirrhosis?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **7**

Question	Yes	No
7. Has the patient been receiving ursodiol therapy for one year or greater and has had an inadequate response?	☐ Yes Proceed to question **9**	☐ No Proceed to question **8**
8. Is the patient unable to tolerate ursodiol therapy?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Does the patient have a contraindication to, intolerability to, or has failed a trial of obeticholic acid (Ocaliva)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
10. Has the patient responded to the requested medication as determined by the prescribing physician [for example, improved biochemical markers of primary biliary cholangitis (PBC): alkaline phosphatase, bilirubin, gamma-glutamyl transpeptidase, aspartate aminotransferase, alanine aminotransferase]?	☐ 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

[12 February 2025]

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