Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Ocaliva
(obeticholic acid)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
Ocaliva 5mg: ☐ Ocaliva 10mg: ☐ ICD10:

Directions for use: Quantity: Duration of therapy:

If using more than 1 tablet per day, please provide clinical rational for this dosing, including reason why patient is taking 2x5mg tablets versus 1x10mg, if applicable:

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Clinical Information:

****This drug requires supportive documentation (i.e. genetic testing, chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.****

Is this a new start or continuation of therapy? ☐ new start ☐ continued therapy

(if continued therapy) Does your patient have documented beneficial clinical response to Ocaliva? ☐ Yes ☐ No

Please provide documentation to support.

Does your patient have any of the following? Supportive documentation must be provided.

- ☐ history of elevated alkaline phosphatase (ALP) for at least 6 months
- ☐ presence of antimitochondrial antibody (AMA) OR, if AMA is negative or in low titer (less than 1:80), PBC specific antibodies (anti-GP210 and/or anti-SP100 and/or antibodies against the major M2 components [PDC-E2, 2-oxo-glutaric acid dehydrogenase complex])
- ☐ evidence of PBC on liver biopsy
- ☐ none of the above

Has your patient ever been treated with ursodiol (Actigall, Urso, Urso Forte)? ☐ Yes ☐ No

(if no ursodiol) Does your patient have a contraindication per FDA label to ursodiol therapy? ☐ Yes ☐ No

(if yes) What is the contraindication?

(if ursodiol) Was your patient treated for at least 6 months with ursodiol?

- ☐ Yes
- ☐ No, due to patient didn't tolerate ursodiol
- ☐ No, due to another reason

(if less than 6 months) What was the intolerance or reason that your patient stopped ursodiol?

Please provide chart notes to document this.

(if 6 or more months) Did your patient have a good (adequate) response to ursodiol therapy? ☐ Yes ☐ No

(if no) Which of the following was evidence of your patient's inadequate response to ursodiol therapy?

- ☐ inadequate reduction of alkaline phosphatase (ALP) (greater than or equal to 1.67 times the upper limit of normal)
- ☐ inadequate reduction of total bilirubin (greater than the upper limit of normal but less than two times the upper limit of normal)

☐ evidence of disease progression on biopsy
☐ other
(if other) Please explain.

(if no) Will your patient be using Ocaliva in combination with ursodiol?

Additional Pertinent Information: *(please include clinical support for the use of this drug in your patient, including complications of disease):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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