CONTAINS CONFIDENTIAL PATIENT INFORMATION

Cholbam (cholic acid)

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:
Prior Authorization of Benefits Center at 1-844-512-9004
Provider Help Desk 1-800-454-3730

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Patient Name: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
Patient Phone #: _____	Physician Specialty: _____
Patient Email Address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician Email Address: _____

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
Cholbam (cholic acid)	_____	_____	Specify: _____

7. DIAGNOSIS: _____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

☐ Yes ☐ No	Patient has a diagnosis of bile acid synthesis disorder due to a single enzyme defect (SED) including (please indicate): ☐ 3-beta-hydroxy-delta-5c27-steroid oxidoreductase deficiency (3-βHSD) ☐ Aldo-keto reductase 1D1 (AKR1D1) ☐ Alpha-methylacyl-CoA racemase deficiency (AMACR deficiency) ☐ Sterol 27-hydroxylase deficiency (cerebrotendinous xanthomatosis [CTX]) ☐ Cytochrome P450 7A1 (CYP7A1) ☐ 25-hydroxylation pathway (Smith-Lemli-Opitz)
☐ Yes ☐ No	Cholbam (cholic acid) is being prescribed as an adjunctive treatment of peroxisomal disorder (PD) in patients who exhibit manifestations of liver disease, steatorrhea, or complications from fat soluble vitamin absorption. Peroxisomal disorders include Zellweger syndrome (ZWS), neonatal adrenoleukodystrophy (NALD), or infatile refsum disease (IRD)
☐ Yes ☐ No	Cholbam (cholic acid) is being prescribed by a hepatologist or pediatric gastroenterologist
☐ Yes ☐ No	Diagnosis is confirmed by mass spectrometry or other biochemical testing or genetic testing (documentation* must be provided)
☐ Yes ☐ No	Baseline liver function tests are taken prior to initiation of therapy (AST. ALT, GGT, ALP, total bilirubin, INR) and provided with request (documentation* must be provided)
☐ Yes ☐ No	Patient has elevated serum aminotransferases (AST and ALT) with normal serum gamma glutamyltransferase (GTT)
☐ Yes ☐ No	Patient is at least 3 weeks old

PAGE 1 OF 2, CONTINUED ON PAGE 2

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Patient Name: _____ **Patient ID#:** _____

Requests for Continued Therapy:

□ Yes	□ No	Body weight has increased by 10% or is stable at ≥50th percentile
□ Yes	□ No	Alanine aminotransferase (ALT) or aspartate aminotransferase (AST) < 50 U/L or baseline levels reduced by 80%
□ Yes	□ No	Total bilirubin level reduced to ≤1mg/dL

***Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.**

9. PHYSICIAN SIGNATURE

_____ _____
Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.