Amerigroup

Medicaid

Cholestatic pruritis agents prior authorization of benefits form

Contains confidential patient information
Complete form in its entirety and fax to: Prior authorization of benefits center at **844-474-3341.**

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**
			Specify:
7. Diagnosis:			

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

□ Yes □ No Is this a renewal request?
□ Yes □ No Does the client have a diagnosis of progressive familial intrahepatic cholestasis (PFIC) confirmed with genetic testing?
□ Yes □ No Does the client have a diagnosis of PFIC type 2 with ABCB11 variants resulting in non-functional or complete absence of bile salt export pump protein (BSEP3)?
□ Yes □ No Does the client have a history of liver transplant?
□ Yes □ No Does the client have a history of biliary diversion surgery in the last 180 days?
□ Yes □ No Has the client had at least 90 days therapy in the last 180 days of a standard agent used for the treatment of cholestatic pruritis (for instance, Cholestyramine, Naltrexone, Prevalite, Questran, Rifampin, Sertraline, Urso, Urso Forte, Ursodiol, Zoloft)?
□ Yes □ No Does the client have an ALT and total bilirubin that is less than (<) 10 times the upper limit of normal (ULN)?
□ Yes □ No Does the client have a diagnosis of Alagille syndrome confirmed with genetic testing?
□ Yes □ No Will the client have concurrent therapy with another ileal bile acid transporter (IBAT) inhibitor?

For the *Medicaid Preferred Drug List*, please refer to the Medicaid Vendor Drug Program website at **https://www.txvendordrug.com/formulary/formulary-search**

https://provider.amerigroup.com/TX

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.	
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