US Family Health Plan

Prior Authorization Request Form for

Elafibranor (Iqirvo)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization of initial therapy is 1 year. For renewal of therapy an initial USFHP 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:**

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 **11**	☐ No Proceed to question **2**
2. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have a diagnosis of primary biliary cholangitis (PBC)?	☐ Yes Proceed to question **4**	☐ 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?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the requested medication prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician?	☐ Yes Proceed to question **6**	☐ 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?	☐ Yes Proceed to question **8**	☐ No Proceed to question **7**

7. Is the patient unable to tolerate ursodiol therapy?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Does the patient have a contraindication to obeticholic acid (Ocaliva)?	☐ Yes **Sign and date below**	☐ No Proceed to question **9**
9. Does the patient have an intolerability to obeticholic acid (Ocaliva)?	☐ Yes **Sign and date below**	☐ No Proceed to question **10**
10. Has the patient failed a trial of obeticholic acid (Ocaliva)?	☐ Yes **Sign and date below**	☐ 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)?	☐ 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