US Family Health Plan

Prior Authorization Request Form for

Maralixibat (Livmarli)

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**

Initial therapy approves for 6 months.

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 Livmarli.*	☐ Yes (subject to verification) **Proceed to question 8**	☐ No **Proceed to question 2**
2. Is the requested medication prescribed by a pediatric gastroenterologist, or pediatric hepatology transplant specialist?	☐ Yes **Proceed to question 3**	☐ No **STOP Coverage not approved**
3. Is the patient greater than or equal to 3 months of age?	☐ Yes **Proceed to question 4**	☐ No **STOP Coverage not approved**
4. Has documentation been submitted to confirm that the patient has a diagnosis of Alagille syndrome (ALGS) with severe refractory pruritus? Non FDA approved used are not approved including PFIC, NAFLD, NASH, biliary atresia, and other cholestatic diseases. **PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.**	☐ Yes **Proceed to question 5**	☐ No **STOP Coverage not approved**
5. Has the patient been evaluated for possible orthotopic liver transplant (OLT)?	☐ Yes **Proceed to question 6**	☐ No **STOP Coverage not approved**

6. Has the patient tried and failed or had intolerance to ALL of the following: ursodiol, bile acid sequestrant (for example cholestyramine, colesevelam), rifampin, naltrexone, antihistamine (for example, hydroxyzine, diphenhydramine)? Note: The dates and durations of therapy for each medication or contraindication to each medication listed below must be provided or your case could be denied.	☐ Yes **Proceed to question 7**	☐ No **STOP** **Coverage not approved**

7. Please provide the date of trial and response to treatment for each medication below:

Drug	Date of Trial	Response to therapy
Ursodiol		
Bile acid sequestrant (for example cholestyramine, colesevelam)		
Rifampin		
Naltrexone		
Antihistamine (for example hydroxyzine, diphenhydramine)		

Note: The dates and durations of therapy for each medication or contraindication to each medication listed below must be provided or your case could be denied.

Sign and date below

8. Has documentation been submitted to confirm that the patient has demonstrated significant improvement in pruritus symptoms? **PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.**	☐ Yes **Proceed to question 9**	☐ No **STOP** **Coverage not approved**
9. Will Livmarli be discontinued if the patient undergoes liver transplant?	☐ 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