HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
BYLVAY™

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Bylvay™ (odevixibat)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
PRURITUS WITH PROGRESSIVE FAMILIAL INTRAHEPATIC CHOLESTASIS			
1. Is the request by, or in consultation with, a hepatologist, gastroenterologist, or a physician that specializes in progressive familial intrahepatic cholestasis?	☐	☐	**Please provide documentation**
2. Does the member have a diagnosis of progressive familial intrahepatic cholestasis with moderate-to-severe pruritus?	☐	☐	**Please provide documentation**
3. Is the diagnosis confirmed by documented genetic testing demonstrating a gene mutation affiliated with progressive familial intrahepatic cholestasis?	☐	☐	**Please provide documentation**
4. Does the member have a serum bile acid concentration above the upper limit of the normal reference range?	☐	☐	**Please provide documentation**
5. Has the member tried and failed all of the following systemic therapies, unless contraindicated or intolerant: • cholestyramine • rifampicin • ursodiol • sertraline • phototherapy	☐	☐	**Please provide documentation**

6. Does the member have cirrhosis, portal hypertension, or history of a hepatic decompensation event (variceal hemorrhage, ascites, and hepatic encephalopathy)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does the member have a continued medical need for therapy?	☐	☐	**Please provide documentation**
3. Has the member experienced a positive clinical response to therapy?	☐	☐	**Please provide documentation**
4. Does the member have cirrhosis, portal hypertension, or history of a hepatic decompensation event (variceal hemorrhage, ascites, and hepatic encephalopathy)?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

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Policy PHARM-126
Origination Date: 12/16/2021
Reviewed/Revised Date: 01/18/2023
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