HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM
LIVMARLI™

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department at 385-425-4052.

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: 385-425-5094

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: ☐ Livmarli™ (maralixibat)

Dosing/Frequency:_____

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

Questions	Yes	No	Comments/Notes
MODERATE TO SEVERE CHOLESTATIC PRURITIS			
1. Is the request prescribed by a hepatologist, gastroentologist, or provider specialized in Alagille syndrome?	☐	☐	**Please provide documentation**
2. Is the member ≥ 12 months and ≤ 18 years of age at therapy initiation?	☐	☐	**Please provide documentation**
3. Does the member have a clinical diagnosis of Alagille Syndrome confirmed by genetic testing with one of the following: • JAG1: Deletion or mutation • NOTCH2: Deletion or mutation	☐	☐	**Please provide documentation**
4. Does the member have at lease one of the following markers for cholestasis: • Gamma-glutamyl transferase > 3 times above the upper limit of normal reference range • Total serum bile acid > 3 times above the upper limit of normal reference range • Conjugated bilirubin > 1 mg/dL • Unexplainable fat-soluble vitamin deficiency • Intractable pruritus due to liver disease	☐	☐	**Please provide documentation**
5. Does the member have a documented daily score > 2 in the Itch Reported Outcome (ItchRO™) assessment for two consecutive weeks?	☐	☐	**Please provide documentation**

6. Has the member trialed all of the following medications with inappropriate clinical response, unless contraindicated: • Rifampin • Cholestyramine • Ursodeoxycholic acid • Antihistamines	☐	☐	**Please provide documentation**
7. Does the member have any of the following conditions: • Concomitant liver disease • History of decompensated cirrhosis (e.g., ascites, encephalopathy, variceal hemorrhage)	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the requesting for reauthorization of therapy?	☐	☐	
2. Has the member responded to initial therapy with a positive clinical response demonstrated by a decrease in pruritis severity or decrease in serum bile acid?	☐	☐	**Please provide documentation**
3. Has the member experienced a hepatic decompensation event (e.g., ascites, encephalopathy, variceal hemorrhage)?	☐	☐	**Please provide documentation**
4. Does the member have a concomitant liver disease?	☐	☐	**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-HU-133
Origination Date: 03/09/2022
Reviewed/Revised Date: 03/15/2023
Next Review Date: 03/15/2024
Current Effective Date: 04/01/2023