Prior Authorization Form

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for requested authorization(s). Attach additional sheets to this form if necessary.

Please fax the completed PA form and any additional informational sheets to Nirvanahealth at the following fax number: +1(866) 871-8565

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Health Plan Name:		Prescriber Address:	
Patient Insurance Id:			
Patient Date of Birth:		Prescriber Phone:	( )
Patient Phone:		Prescriber Fax:	( )
		Prescriber Specialty:	
		Prescriber DEA:	
		Prescriber NPI:	

Medication & Medical Information	
Requested Drug(s) & Strength(s):	[ ] Livmarli 9.5 mg/mL oral solution
Requested Daily Quantity Limit – Amount:	
Requested Daily Quantity Limit – Days:	
Expected Length of Therapy:	
Directions:	
Diagnosis and Diagnosis Codes (ICD-10 Standard Codes):	
List drugs used previously to treat the same condition:	
Additional clinical information or history. Please include any relevant test results and/or medical record notes:	

Questionnaire

Q1: I, as the provider or designated representative of the provider, certify and attest that the information provided is complete and accurate and that, upon request, I shall provide any information to RxAdvance that RxAdvance determines is reasonably necessary to verify my responses. (Check only one that apply)

[ ] Yes

[ ] No

Q2: Is the member currently treated with this medication? (Check only one that apply)

[ ] Yes (please list start date of therapy (month/day/year)) _____ (*Required)

[ ] No

Q3: What is the member's diagnosis? (Check only one that apply)

[ ] Alagille syndrome (ALGS) _____(*Required)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

Q4: Does the member have documentation of positive clinical response to therapy (e.g., reduced bile acids, reduced pruritus severity score)? (Check only one that apply)

[ ] Yes (please provide the supporting documents) _____ (*Required)

[ ] No (please provide medical justification for continuation of therapy) _____(*Required)

Q5: What is the member's diagnosis? (Check only one that apply)

[ ] Alagille syndrome (ALGS) _____(*Required)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

Q6: Is the molecular genetic testing confirmed mutations in the JAG1 or NOTCH2 gene? (Check only one that apply)

[ ] Yes (please provide the supporting documents) _____ (*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q7: Does the member have documentation of total serum bile acid greater than 3 times the upper limit of normal (ULN)? (Check only one that apply)

[ ] Yes (please provide the supporting documents) _____ (*Required)

[ ] No

Q8: Does the member have documentation of conjugated bilirubin greater than 1 mg/dL? (Check only one that apply)

[ ] Yes (please provide the supporting documents) _____ (*Required)

[ ] No

Q9: Does the member have documentation of fat soluble vitamin deficiency which is otherwise unexplainable? (Check only one that apply)

[ ] Yes (please provide the supporting documents) _____ (*Required)

[ ] No

Q10: Does the member have documentation of gammaglutamyl transpeptidase (GGT) greater than 3 times the ULN? (Check only one that apply)

[ ] Yes (please provide the supporting documents) _____ (*Required)

[ ] No

Q11: Is the member experiencing moderate to severe cholestatic pruritus? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q12: Has the member had an inadequate response to at least two of the following treatments used for the relief of pruritus? ((a) Ursodeoxycholic acid (e.g., Ursodiol), b) Antihistamines (e.g., diphenhydramine, hydroxyzine), c) Rifampin, or d) Bile acid sequestrants (e.g., Questran, Colestid, Welchol) (Check only one that apply)

[ ] Yes (please specify drug names and the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q13: Is the member at least 1 years old? (Check only one that apply)

[ ] Yes

[ ] No (please provide member's age and clinical rationale for the request)
_____(*Required)

Q14: Is the requested drug prescribed by or in consultation with a hepatologist? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, Insurer, Medical Group or its designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Signature of Prescriber or Authorized Representative:	Date:
Print Authorized Representative Name:	