



**Request for Prior Authorization**

**MARALIXIBAT (LIVMARLI)**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

**Diagnosis (Attach copy of genetic testing):** \_\_\_\_\_

**Prescriber Specialty:**  Hepatologist  Gastroenterologist  Prescriber specializing in ALGS  
 Other (specify): \_\_\_\_\_

If other, note consultation with hepatologist, gastroenterologist, or prescriber specializing in ALGS:

Consultation date: \_\_\_\_\_

Physician name, specialty & phone: \_\_\_\_\_

**Does patient have cholestasis with moderate to severe pruritis?**  No  Yes

**Patient's current weight in kg:** \_\_\_\_\_

**Document trials, at a therapeutic dose, with two of the following agents:**

**Ursodeoxycholic acid (ursodiol) Trial:**

Dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

**Cholestyramine Trial:**

Dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

**Rifampin Trial:**

Dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

**Renewal Requests:**

**Patient's current weight in kg:** \_\_\_\_\_

**Document an improvement in pruritis symptoms:** \_\_\_\_\_

**Attach lab results and other documentation as necessary.**

Prescriber signature (Must match prescriber listed above.)	Date of submission
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**IMPORTANT NOTE:** In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.