

Request for Prior Authorization

FAX Completed Form To I (800) 574-2515

Provider Help Desk 1 (877) 776-1567

MARALIXIBAT (LIVMARLI)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

			ELASETRINT - ACCORD							
IA Medicaid Mei	mber ID #	Pa	tient name			DOB				
Patient address										
Provider NPI			Prescriber name			Phone				
Prescriber address							Fax			
Pharmacy name			Address			Phone	Phone			
Proscribor mus	st complete all inf	ormation	above. It must be legibl	o correct and co	mplete er	form will	ho roturr			
Pharmacy NPI			Pharmacy fax		NDC					
Prior authoriza	ation (PA) is red	uired fo	r maralixibat (Livmarl	i). Requests for	non-prefe	rred age	nts mav	be		
Prior authorization (PA) is required for maralixibat (Livmarli). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:										
 Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 										
 Patient has a diagnosis of Alagille syndrome (ALGS) confirmed by genetic testing demonstrating a JAGI or NOTCH2 mutation or deletion; and 										
3) Patient has cholestasis with moderate to severe pruritis; and										
 Is prescribed by or consultation with a hepatologist, gastroenterologist, or a prescriber who specializes in ALGS; and 										
5) Document agents:	ation of previou	s trials a	and therapy failures, at	a therapeutic d	lose, with a	at least t	wo of th	e follov	wing	
a. Ursodeoxycholic acid (ursodiol)b. Cholestyraminec. Rifampin; and										
6) Patient's current weight in kilograms (kg) is provided.										
The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.										
Request for co			authorization will be g ill require documentat						ment.	
Non-Preferre	<u>ed</u>									
Livmarli										
	Strength	D	osage Instructions	Quantity	, D	ays Sup	ply			

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MARALIXIBAT (LIVMARLI)

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Diagnosis (Attach copy of genetic testing):								
Prescriber Specialty: ☐ Hepatologist ☐ Gastroenterologist ☐ P ☐ Other (specify):	rescriber specializing in ALGS							
If other, note consultation with hepatologist, gastroenterologist, or prescriber specializ	ing 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 age	nts:							
Ursodeoxycholic acid (ursodiol) Trial: Dose: Trial d	ates:							
Failure reason:								
Cholestyramine Trial:								
e: 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							

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.

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