GHP Family Pharmacy Customer Service
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Geisinger

CHOLBAM (cholic acid) PRIOR AUTHORIZATION FORM *(Form effective 01/31/17)*

- Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request.
- Prior authorization guidelines and quantity limits may be found in Geisinger Health Plan's Quantity Limit Policy 1341.0F – **Bile Salts and Quantity Limits/Daily Dose Limits** accessible on Geisinger Health Plan's website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

PRIOR AUTHORIZATION REQUEST INFORMATION			PRESCRIBER INFORMATION	
☐ New request ☐ Renewal request	☐ Additional info PA#:_____	# of pages in request: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			State license #:	
LTC facility contact/phone:			NPI:	MA Provider ID#:
RECIPIENT INFORMATION			Street address:	
Recipient name:			Suite #:	City/state/zip:
Recipient ID#:	DOB:		Phone:	Fax:

CLINICAL INFORMATION

Drug requested: Cholbam capsule	Strength:	Quantity:
Directions:		Refills:
Diagnosis:		Dx code *(required)*:

Section A: Initial Cholbam requests

1. If prescriber is NOT a hepatologist or pediatric gastroenterologist, is the requested medication being prescribed in consultation with one of the above specialists?	☐ Yes – *submit documentation of consultation* ☐ No or not applicable
2. Does the Recipient have one of the following diagnoses? ☐ bile acid synthesis disorder (BASD) due to a single enzyme defect (SED) ☐ peroxisomal disorder (PD) (including Zellweger spectrum disorder)	☐ Yes – *submit results and dates of mass spectrometry or other biochemical or genetic testing* ☐ No – *submit documentation supporting the use of Cholbam for Recipient's diagnosis*
3. *For a diagnosis of peroxisomal disorder*, will Cholbam be used in addition to other therapy/treatment?	☐ Yes – *submit documentation of concurrent therapy or treatment* ☐ No
4. Does the Recipient have results of the following baseline (before starting Cholbam) lab tests? ☐ AST ☐ GGTP ☐ bilirubin ☐ ALT ☐ alkaline phosphatase ☐ INR	☐ Yes – *submit results and dates of all lab monitoring for all requested values* ☐ No

Section B: Renewal Cholbam requests

1. Does the recipient have documentation of the following lab results since starting Cholbam and within the past 6 months? ☐ AST ☐ GGT ☐ bilirubin ☐ ALT ☐ alkaline phosphatase ☐ INR		☐ Yes – *submit results and dates of all lab monitoring for all requested values* ☐ No
2. Has the Recipient shown clinical signs or symptoms or lab indicators of any of the following since starting Cholbam?	☐ complete biliary obstruction ☐ persistent or ongoing worsening of liver function ☐ persistent or ongoing cholestasis	☐ Yes ☐ No *Submit medical record documentation of clinical monitoring*
3. *For the FIRST RENEWAL REQUEST after starting or restarting Cholbam*, has the Recipient experienced an improvement in liver function within the first 3 months of treatment?		☐ Yes – *submit results and dates of baseline LFTs and LFTs drawn 3 months after starting/restarting Cholbam* ☐ No

Please submit to PromptPA https://ghp.promptpa.com OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

Prescriber Signature:	Date: