New Hampshire AIDS Drug Assistance Program
Prior Authorization
Primary Biliary Cholangitis

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME: **FIRST NAME:**

MEDICAID ID NUMBER: **DATE OF BIRTH:** – –

GENDER: ☐ Male ☐ Female

Drug Name **Strength**

Dosing Directions **Length of Therapy**

SECTION II: PRESCRIBER INFORMATION

LAST NAME: **FIRST NAME:**

SPECIALTY: **NPI NUMBER:**

PHONE NUMBER: – – **FAX NUMBER:** – – –

SECTION III: CLINICAL HISTORY

1. Is the prescriber a gastroenterologist, hepatologist, or has one been consulted? ☐ Yes ☐ No
2. Has the diagnosis of primary biliary cholangitis been confirmed by at least 2 of the following? Check all that apply.
   - ☐ Biochemical evidence of cholestasis with an alkaline phosphatase (ALP) elevation
   - ☐ Presence of antimitochondrial antibody (AMA) titer > 1:80
   - ☐ If AMA is negative or present only in low titer (≤ 1:80), presence of other PBC-specific autoantibodies, including sp100 or gp210
   - ☐ Histologic evidence of nonsuppurative destruction cholangitis and destruction of interlobular bile ducts
3. Provide the baseline ALP_____/date _____ Baseline total bilirubin _____/date _____

(Form continued on next page.)

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PATIENT LAST NAME:

PATIENT FIRST NAME:

4. Does the patient have one of the following? Check all that apply.
   - ☐ Prior hepatic decompensation event
   - ☐ Patient has had an inadequate response to treatment with UDCA after 1 year of therapy (ALP > normal and/or total bilirubin greater than the upper limit of normal [ULN] but less 2 times ULN) and the treatment plan includes continued UDCA with the requested drug
   - ☐ Patient has an intolerance or hypersensitivity to UDCA
   - ☐ Patient has an FDA-labeled contraindication to UDCA
5. Does the patient have decompensated cirrhosis (e.g., ascites, variceal bleeding, hepatic encephalopathy)? ☐ Yes ☐ No
6. Does the patient have complete biliary obstruction? ☐ Yes ☐ No
7. Attestation: Does the prescriber attest that the patient will be monitored for adverse reactions according to the product labeling? ☐ Yes ☐ No

PRESCRIBER'S SIGNATURE: _____ DATE: _____