This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

2.	Does the patient have or has the patient developed decompensated cirrhosis (e.g., ascites, variceal bleeding, hepatic encephalopathy)?	**Y** ☐	**N** ☐
3.	Is the requested drug being prescribed by or in consultation with a hepatologist or gastroenterologist?	**Y** ☐	**N** ☐
4.	Is the patient currently receiving treatment with the requested drug?	**Y** ☐	**N** ☐
5.	Has the patient achieved or maintained a clinical benefit from Livdelzi therapy?	**Y** ☐	**N** ☐
6.	Which of the following clinical benefits has the patient experienced? ACTION REQUIRED: Please attach documentation of current serum alkaline phosphatase (ALP) and/or current total bilirubin level. ACTION REQUIRED: Submit supporting documentation		
	At least a 15% reduction in serum alkaline phosphatase (ALP) level (If checked, no further questions)	☐	
	Serum ALP level less than 1.67 times upper limit of normal (ULN) (If checked, no further questions)	☐	
	Total bilirubin less than or equal to ULN (If checked, no further questions)	☐	
	None of the above (If checked, no further questions)	☐	
7.	Has the diagnosis of PBC been confirmed by at least two of the following three criteria: A) Biochemical evidence of cholestasis with elevation of alkaline phosphatase (ALP) level for at least 6 months duration, B) Presence of antimitochondrial antibodies (AMA) (titer greater than 1:40 by immunofluorescence or immunoenzymatic reactivity) or PBC-specific antinuclear antibodies (ANA) (e.g., anti-gp210, anti-sp100), or C) Histologic evidence of PBC on liver biopsy (e.g., non-suppurative inflammation and destruction of interlobular and septal bile ducts)?	**Y** ☐	**N** ☐

8. Does the patient have an elevated serum alkaline phosphatase (ALP) level prior to initiating therapy with Livdelzi? ACTION REQUIRED: If Yes, please attach documentation of pretreatment serum alkaline phosphatase (ALP) level. ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

PA Request Criteria

00-000000000

218071

Patient Name: _____ **Date:** 5/13/2025
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: **Patient Phone:** **Physician Name:**
_____ **NPI#:** _____ **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
_
Drug Name (specify drug) _____
Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____
Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

1. What is the diagnosis?

   Primary biliary cholangitis (PBC) (previously known as primary biliary cirrhosis) (If checked, go to 2)

   Other, please specify.

   _____

9. Has the patient had an inadequate response to at least 12 months of prior therapy with ursodeoxycholic acid (UDCA)/ursodiol? **Y** ☐ **N**
10. Will the patient continue concomitant therapy with UDCA/ursodiol? **Y** ☐ **N** ☐ I attest that the
11. Does the patient have an intolerance to therapy with UDCA/ursodiol? If Yes, indicate the patient's intolerance.

    Yes (If checked, go to 12)

    _____

    No (If checked, no further questions)

12. Is the patient 18 years of age or older? **Y** ☐ **N**

medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date