PA Request Criteria

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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.

**Patient Name:** _____ **Date:** 10/9/2026
**Patient ID:** _____ **Patient Date Of Birth:** _____
**Patient Group No:** _____ **Patient Phone:** _____ **Physician Name:**
**NPI#:** **Specialty:**
**Physician Office Address:** _____ **Physician Office Telephone:**

**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. Will the requested drug be used concomitantly with any other ileal bile acid transporter (IBAT) inhibitor (e.g., Bylvay, Livmarli)? **Y** ☐ **N** ☐

2. What is the diagnosis?
   - Cholestatic pruritis associated with primary biliary cholangitis (PBC) (If checked, go to 3) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

3. Does the patient have decompensated cirrhosis or has the patient had any prior or active hepatic decompensation events (e.g., ascites, variceal hemorrhage, hepatic encephalopathy)? **Y** ☐ **N** ☐

4. Is the requested drug being prescribed by or in consultation with a hepatologist or gastroenterologist? **Y** ☐ **N** ☐

5. Is the patient currently receiving treatment with the requested drug? **Y** ☐ **N** ☐

6. Is the patient experiencing benefit from therapy (e.g., improvement in pruritus)? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation showing benefit from therapy (e.g., improvement in pruritus). **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

7. Has the diagnosis of primary biliary cholangitis (PBC) been confirmed by at least two of the following 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) 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)? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or laboratory results confirming diagnosis. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

8. Has the patient been evaluated for any other concomitant liver disease (e.g., chronic viral hepatitis, alcoholic liver disease, liver cancer)? **Y** ☐ **N** ☐

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

I attest that the 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**

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