Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
MARALIXIBAT (LIVMARLI)
(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

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:

1) **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**
2) **Patient has a diagnosis of Alagille syndrome (ALGS) confirmed by genetic testing demonstrating a *JAG1* or *NOTCH2* mutation or deletion; and**
3) **Patient has cholestasis with moderate to severe pruritis; and**
4) **Is prescribed by or consultation with a hepatologist, gastroenterologist, or a prescriber who specializes in ALGS; and**
5) **Documentation of previous trials and therapy failures, at a therapeutic dose, with at least two of the following agents:**
   a. **Ursodeoxycholic acid (ursodiol)**
   b. **Cholestyramine**
   c. **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.

If criteria for coverage are met, initial authorization will be given for 6 months to assess the response to treatment. Request for continuation of therapy will require documentation of an improvement in pruritis symptoms and patient's current weight in kg.

Non-Preferred

☐ Livmarli

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

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Diagnosis (Attach copy of genetic testing): _____

Prescriber Specialty: ☐ Hepatologist ☐ Gastroenterologist ☐ Prescriber specializing in ALGS
☐ Other (specify): _____

If other, note consultation with hepatologist, gastroenterologist, or prescriber specializing 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 agents:

Ursodeoxycholic acid (ursodiol) Trial:
Dose:_____ Trial dates:_____
Failure reason:_____

Cholestyramine Trial:
Dose:_____ 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.*