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
Odevixibat (Bylvay)

(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 odevixibat (Bylvay). Payment will be considered under the following conditions:

1. **Request adheres to all FDA approved labeling for indication, including age, dosing, contraindications, warnings and precautions, and drug interactions; and**
2. **Patient has a diagnosis of genetically confirmed progressive familial intrahepatic cholestasis (PFIC) type 1 or type 2; and**
3. **Genetic testing does not indicate PFIC type 2 with ABCB 11 variants encoding for nonfunction or absence of bile salt export pump protein (BSEP-3); and**
4. **Patient has moderate to severe pruritis associated with PFIC; and**
5. **Patient's current weight in kg is provided; and**
6. **Is prescribed by or in consultation with a hepatologist or gastroenterologist.**

Initial authorizations will be approved for 3 months for initial treatment or after a dose increase. Additional authorizations will be considered when the following criteria are met:

1. **Patient's current weight in kg is provided; and**
2. **Documentation is provided the patient has responded to therapy and pruritis has improved. If there is no improvement in pruritis after 3 months of treatment with the maximum 120 mcg/kg/day dose, further approval of odevixibat will not be granted.**

Non-Preferred

☐ Bylvay

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

Does genetic testing indicate PFIC type 2 with ABCB 11 variants for encoding for nonfunction or absence of bile salt export pump protein (BSEP-3) (attach supporting documentation)? ❑ Yes ❑ No

Does patient have moderate to severe pruritis associated with PFIC? ❑ Yes ❑ No

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Request for Prior Authorization-*Continued*
Odevixibat (Bylvay)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Provide patient's current weight in kg: _____ Date obtained: _____

Prescriber Specialty: ❑ Hepatologist ❑ Gastroenterologist
❑ Other (specify): _____

If other, note consultation with hepatologist or gastroenterologist:
Consultation date: _____
Physician name, specialty & phone: _____

Renewal Requests

Provide patient's current weight in kg: _____ Date obtained: _____

Has patient responded to therapy and pruritis improved? ❑ Yes ❑ No

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.*