Iqirvo (elafibranor)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PHONE NUMBER:	**DATE OF BIRTH:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
PATIENT INSURANCE ID NUMBER:		

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**	
NPI NUMBER:	**DEA NUMBER:**	
PHONE NUMBER:	**FAX NUMBER:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
REQUESTER (if different than prescriber):	**OFFICE CONTACT PERSON:**	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ **YES** (if yes, complete below) ☐ **NO**		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Primary biliary cholangitis (PBC) (previously known as primary biliary cirrhosis) ☐ Other diagnosis: _____ ICD-10 Code(s):	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Initial:

Will the patient be using the drug as a part of the clinical trial? ☐ Yes ☐ No

Is the medication being prescribed by, or in consultation with, a hepatologist or gastroenterologist?
☐ Yes ☐ No

Was the diagnosis of PBC was confirmed by any of the following criteria? ☐ Yes ☐ No
Please select all that apply.

- **Biochemical evidence of cholestasis with elevation of alkaline phosphatase (ALP) level for at least 6 months duration.**
- **Presence of antimitochondrial antibodies (AMA) (titer >1:40 by immunofluorescence or immunoenzymatic reactivity) or PBC-specific antinuclear antibodies (ANA) (e.g., anti-gp210, antisp100).**
- **Histologic evidence of PBC on liver biopsy (e.g., non-suppurative inflammation and destruction of interlobular and septal bile ducts)**

Does the patient has elevated serum ALP level prior to starting therapy with the requested agent?
☐ Yes ☐ No

Has the patient has been receiving ursodiol therapy for at least 1 year and has had an inadequate response (documentation required)? ☐ Yes ☐ No

If no, was the patient unable to tolerate ursodiol therapy (documentation required)? ☐ Yes ☐ No

Does the patient have alkaline phosphatase (ALP) greater than 1.67 times the upper limit of normal?
☐ Yes ☐ No

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Does the patient have a total billirubin less than 2 times the upper limit of normal? ☐ **Yes** ☐ **No**

Does the patient have hepatic decompensation? ☐ **Yes** ☐ **No**

Have all other causes of chronic liver disease have been ruled out? ☐ **Yes** ☐ **No**

Will Iqirvo (elafibranror) be used in combination with Livdelzi (seladelpar)? ☐ **Yes** ☐ **No**

Renewal:

Has the patient had at least a 15% reduction in serum ALP level (documentation required)?
☐ **Yes** ☐ **No**

Did the patient's ALP level decrease to 1.67 times upper limit of normal (documentation required)?
☐ **Yes** ☐ **No**

Did the patient's total bilirubin decrease to less than or equal to upper limit of normal (documentation required)? ☐ **Yes** ☐ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909