Relyvrio (sod phenylbutyrate/taurursodiol)
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: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

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:**
REQUESTOR (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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Magellan Rx Management – Commercial Clients.
CAT0295 5.1.2023

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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:**
☐ Amyotrophic Lateral Sclerosis (ALS) ☐ Other diagnosis: _____ICD-10_____	

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

Clinical Information:

Initial Approval:

Is this drug being prescribed to this patient as part of a treatment regimen specified within a sponsored clinical trial? ☐ Yes ☐ No

Ia prescriber a neurologist? ☐ Yes ☐ No

Has the patient been diagnosed with clinically definite or probable ALS based on El Escorial revised criteria or Awaji criteria? ☐ Yes ☐ No (documentation required)

Has the patient had a diagnosis of ALS for less than or equal to 18 months? ☐ Yes ☐ No (documentation required)

Is the patient's percent-predicted forced vital capacity (%FVC) greater than or equal to 60%? ☐ Yes ☐ No (documentation required)

Does the patient have retained functionality for most activities of daily living as indicated by an ALSFRS-R score of greater than or equal to 2 or better on each individual item of the ALS Functional Rating Scale – Revised (ALSFRS-R)? ☐ Yes ☐ No (documentation required)

Renewal:

Has patient had a decline in their ALSFRS-R score of greater than 8 points during a 6-month treatment period? ☐ Yes ☐ No Please provide documentation of ALSFRS-R score.

Does patient have a cumulative score on the ALSFRS-R of ≤ 3? (documentation required of ALSFRS-R score required)? ☐ Yes ☐ No

Is patient dependent on invasive ventilation or tracheostomy? ☐ Yes ☐ No

Is prescriber a neurologist? ☐ Yes ☐ No

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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: Magellan Rx Management Prior Authorization Program
Attn:CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909

CAT0295 5.1.2023