New Hampshire Medicaid Fee-for-Service (FFS) Program
Prior Authorization
Cholestatic Pruritus

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH: – –

GENDER: ☐ Male ☐ Female

Drug Name

Strength

Dosing Directions

Length of Therapy

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER: – –

FAX NUMBER: – –

SECTION III: CLINICAL HISTORY

Progressive Familial Intrahepatic Cholestasis (PFIC)

1. Is the prescriber a gastroenterologist, hepatologist, or dermatologist, or has one been consulted? ☐ Yes ☐ No
2. Does the patient have PFIC type 1 or type 2 confirmed by a genetic test? ☐ Yes ☐ No
3. What is the patient's bile acid concentration? _____
4. Is the patient experiencing moderate to severe pruritus? ☐ Yes ☐ No
5. Has the patient tried any of the following for the treatment of pruritus? Check all that apply.
   - ☐ Ursodiol
   - ☐ Cholestyramine
   - ☐ Rifampin
   - ☐ Naloxone/Naltrexone
   - ☐ Any antihistamine

(Form continues on next page.)

New Hampshire Medicaid Fee-for-Service (FFS) Program
Prior Authorization/Non-Preferred Drug Approval Form
Cholestatic Pruritus

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

PATIENT FIRST NAME:

6. Attestation: I have reviewed that the benefits outweigh the risks in this patient who has the following:
   - ☐ Chronic diarrhea requiring ongoing intravenous fluid or nutritional intervention
   - ☐ Prior hepatic decompensation event
   - ☐ Decompensated cirrhosis
   - ☐ An international normalized ration (INR) > 1.4
   - ☐ Another concomitant liver disease
   - ☐ Not applicable (Please explain below.)

   _____

7. Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.

Alagille Syndrome (ALGS)

1. Is the prescriber a gastroenterologist, hepatologist, or dermatologist, or has one been consulted? ☐ Yes ☐ No
2. Does the patient have a diagnosis of Alagille syndrome? ☐ Yes ☐ No
3. Does the patient have evidence of cholestasis? Provide evidence of any that apply. ☐ Yes ☐ No
   - ○ Serum bile acid > 3 times upper limit of normal (ULN) for age _____
   - ○ Conjugated bilirubin > 1 mg/dL_____
   - ○ Gamma glutamyl transferase (GGT) > 3 times ULN for age_____
   - ○ Fat soluble vitamin deficiency not otherwise explained_____
   - ○ Intractable pruritus only explained by liver disease_____
4. Is the patient experiencing moderate to severe pruritus? ☐ Yes ☐ No
5. Has the patient tried any of the following for the treatment of pruritus? Check all that apply.
   - ☐ Ursodiol
   - ☐ Cholestyramine
   - ☐ Rifampin
   - ☐ Naloxone/Naltrexone
   - ☐ Any antihistamine

(Form continues on next page.)

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DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

PATIENT FIRST NAME:

6. Attestation: I have reviewed that the benefits outweigh the risks in this patient who has the following:

- ☐ Chronic diarrhea requiring ongoing intravenous fluid or nutritional intervention
- ☐ Prior hepatic decompensation event
- ☐ Decompensated cirrhosis
- ☐ An international normalized ration (INR) > 1.4
- ☐ Another concomitant liver disease
- ☐ Not applicable (Please explain below.)

_____

PRESCRIBER'S SIGNATURE: _____ **DATE:** _____