



HEPATIC AND BILIARY AGENTS PRIOR AUTHORIZATION FORM (form effective 1/5/2026)

Prior authorization guidelines for **Hepatic and Biliary Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.pa.gov/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services>.

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		Total pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			NPI:	State license #:
LTC facility contact/phone:			Street address:	
Beneficiary name:			City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Drug requested:	Strength:		
Dose/directions:	Quantity:	Refills:	
Diagnosis (<i>submit documentation</i>):	Dx code (<i>required</i>):		

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

1. For CHOLBAM (cholic acid):

- Cholbam (cholic acid) is prescribed by or in consultation with a hepatologist or pediatric gastroenterologist
- Medical history and lab test results support the beneficiary's diagnosis (eg, serum or urinary bile acid levels using mass spectrometry, neurologic exam)

2. For a PPAR AGONIST (e.g., Iqirvo [elafibranor], Livdelzi [seladelpar lysine]):

- The requested drug is prescribed by or in consultation with a hepatologist or gastroenterologist
- Medical history and lab test results support the beneficiary's diagnosis (eg, alkaline phosphatase, antimitochondrial antibodies, histologic evaluation, imaging)
- The beneficiary tried and failed optimally titrated doses of ursodeoxycholic acid (UDCA, ursodiol)
- The beneficiary will take the requested drug in combination with ursodeoxycholic acid (UDCA, ursodiol)
- The beneficiary has a contraindication or history of an intolerance to ursodeoxycholic acid (UDCA, ursodiol)



3. For all other NON-PREFERRED Hepatic and Biliary Agents:

- Tried and failed or has a contraindication or an intolerance to the preferred Hepatic and Biliary Agents (*Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in this class.*)

RENEWAL requests

1. For CHOLBAM (cholic acid):

- Cholbam (cholic acid) is prescribed by or in consultation with a hepatologist or pediatric gastroenterologist
- The beneficiary experienced improvement in liver function within the first 3 months of treatment with Cholbam (cholic acid)
- The beneficiary does NOT have complete biliary obstruction, persistent clinical or lab indicators of worsening liver function, or cholestasis

2. For a PPAR AGONIST (e.g., Iqirvo [elafibranor], Livdelzi [seladelpar lysine]):

- The requested drug is prescribed by or in consultation with a hepatologist or gastroenterologist
- The beneficiary has results of recent LFTs showing a positive clinical response to the requested drug

3. For all other NON-PREFERRED Hepatic and Biliary Agents:

- Tried and failed or has a contraindication or an intolerance to the preferred Hepatic and Biliary Agents (*Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in this class.*)

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:

Date:

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