



# New Hampshire AIDS Drug Assistance 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

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PATIENT FIRST NAME:

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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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  - An international normalized ration (INR) > 1.4
  - Another concomitant liver disease
  - Not applicable (Please explain below.)
- 

**PRESCRIBER'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_