



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit [go.covermymeds.com/OptumRx](http://go.covermymeds.com/OptumRx) to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

## Cholbam<sup>®</sup> Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>		Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			

Clinical Information (required)
<p><b>Continuation of therapy:</b>            Is this a continuation of prior therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No            If "yes" to the above question, please submit documentation (e.g., medical records, chart notes, pharmacy claims) or provide the dates, duration, and previous regimen used below: <b>(REQUIRED)</b></p> <hr/>

<p><b>Select the diagnosis below:</b></p> <input type="checkbox"/> Adjunctive treatment of peroxisomal disorders (PDs) including Zellweger spectrum disorders in patients who exhibit manifestations of liver disease, steatorrhea or complications from decreased fat soluble absorption <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____
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<p><b>Clinical Information:</b>            Is there presence of contraindications or absolute drug interactions with existing therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<p><b>Quantity Limit Requests:</b>            What is the quantity requested per DAY? _____  <b>What is the reason for exceeding the plan limitations?</b></p> <input type="checkbox"/> Titration or loading dose purposes <input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime) <input type="checkbox"/> Requested strength/dose is not commercially available <input type="checkbox"/> Other: _____
<p><b>For continuation of existing therapy, also answer the following:</b>            Would sudden discontinuation of the dose trigger withdrawal symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No            Would discontinuation of the dose be unsafe for the patient and their condition may worsen or exacerbate? <input type="checkbox"/> Yes <input type="checkbox"/> No            Is the prescribing provider attempting to taper or reduce the dose necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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

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Please note: This request may be denied unless all required information is received.  
 For urgent or expedited requests please call 1-855-297-2870.  
 This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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