Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

**Horizon NJ Health**
**Odevixibat (Bylvay) – Medical Necessity Request**
****Complete page 1 for Initial Requests Only****

1. What is the diagnosis?
    a. □ Progressive Familial Intrahepatic Cholestasis
    b. □ Other: _____
2. For members with Progressive Familial Intrahepatic Cholestasis, please answer the following questions:
    a. Is the diagnosis confirmed by genetic testing? **Yes or No**
    b. Does the member have Progressive Familial Intrahepatic Cholestasis Type 2? **Yes or No**
        i. If **Yes,** does genetic testing indicate pathologic variations of the ABCB11 gene that predict non-function or complete absence of the bile salt export pump (BSEP) protein? **Yes or No**
3. Does the member have significant pruritus? **Yes or No**
4. Is the medication prescribed by or in consultation with a hepatologist or gastroenterologist? **Yes or No**
5. Has the member tried and failed ursodeoxycholic acid or other agents used for symptomatic relief of pruritus (e.g., antihistamine, rifampicin, cholestyramine)?
    □ **Yes**: Please provide what therapies (name) the member has tried and failed.
    _____
    □ **No:** Can the member try ursodeoxycholic acid or other agents used for symptomatic relief of pruritus (e.g., antihistamine, rifampicin, cholestyramine) instead?
        □ **Yes**: Please notify the pharmacy of the change and return the form.
        □ **No:** Please provide the reason why:
        _____
6. Is the member's weight being monitored? **Yes or No**
7. What is the member's current weight? _____ lbs or ____ kg

**Physician office's signature*_____ Print Name_____**
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

**Horizon NJ Health**
**Odevixibat (Bylvay) – Medical Necessity Request**
****Complete page 2 only for Subsequent/Renewal requests****

1. Has the member responded positively to therapy? **Yes or No**
    a. If **Yes,** how has the member responded positively to therapy?
        □ Improvement in pruritus
        □ Reduction of serum bile acids from baseline
        □ Other: _____
2. Is the member's weight being monitored? **Yes or No**
3. What is the member's current weight? _____ lbs or ____ kg

**Physician office's signature*_____ Print Name_____**
***Form must be completed and signed by physician or licensed representative from the physician's office**