Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Cholbam
(cholic acid)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested: (*please specify name, strength, and dosing schedule)*
☐ Cholbam 50mg ☐ Cholbam 250mg ICD10:

Patient's current weight: lb. or kg.
Directions for use: Quantity: Duration of therapy:

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:
Does your patient have a bile acid synthesis disorder? Yes ☐ No ☐
(if no) What is the diagnosis related to use? Please provide clinical support for the use of Cholbam for this diagnosis (including pertinent patient history, alternatives tried with date(s) taken and documented results, etc).

What is the cause of your patient's bile acid synthesis disorder?
☐ peroxisomal disorders (PDs), including Zellweger spectrum disorders single enzyme defects (SEDs)
☐ other
(if other) What is the diagnosis related to use? Please provide clinical support for the use of Cholbam for this diagnosis (including pertinent patient history, alternatives tried with date(s) taken and documented results, etc).

Clinical Information:
****This drug requires supportive documentation (i.e. chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.**

Is this a new start or continuation of therapy? ☐ new start ☐ continued therapy
Will your patient be using this drug in combination with Chenodal? Yes ☐ No ☐

if diagnosis is single enzyme defects (SEDs)
(if SEDs) Was your patient's diagnosis confirmed by Fast Atom Bombardment ionization – Mass Spectrometry (FAB-MS) analysis that showed abnormal urinary bile acid consistent with a bile acid synthesis disorder? Yes ☐ No ☐

if SEDs) Are the molecular genetic testing results consistent with the diagnosis (for example, biallelic pathogenic variants in ABCD3, AKR1D1, AMACR, HSD3B7, CYP27A1, or CYP7B)? Yes ☐ No ☐

if diagnosis is peroxisomal disorders (PDs), including Zellweger spectrum disorders
(if PDs) Was your patient's diagnosis confirmed by an abnormal urinary bile acid analysis consistent with a Zellweger spectrum disorder per Fast Atom Bombardment ionization – Mass Spectrometry (FAB-MS)? Yes ☐ No ☐
Notes: Examples include increased concentrations of C27 bile acid intermediates trihydroxycholestanoic acid (THCA) and dihydroxycholestanoic acid (DHCA)

(if PD)s Are the molecular genetic testing results consistent with the diagnosis (for example, biallelic pathogenic variants in one of the PEX genes)? Yes ☐ No ☐

(if PDs) Does your patient have liver disease, steatorrhea, or complications from decreased fat soluble vitamin absorption (for example, rickets)? Yes ☐ No ☐

(if continued therapy) Does your patient have a complete biliary obstruction? Yes ☐ No ☐

(if continued therapy) Will your patient be using this drug in combination with Chenodal? Yes ☐ No ☐

if diagnosis is single enzyme defects (SEDs)

(if continued therapy for SEDs) Has your patient responded to initial Cholbam therapy with an improvement in liver function tests (for example, aspartate aminotransferase [AST], alanine aminotransferase [ALT], bilirubin levels)? Yes ☐ No ☐

if diagnosis is peroxisomal disorders (PDs), including Zellweger spectrum disorders

(if continued therapy for PDs) Has your patient responded to initial Cholbam therapy as per the prescribing physician (for example, improvements in liver enzymes, improvement in steatorrhea)? Yes ☐ No ☐

Additional pertinent information: (*please include clinical support for the use of this drug in your patient, including complications of disease)*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

v050120

Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005