

Prior Authorization Criteria
Relyvrio (sodium phenylbutyrate/taurursodiol)

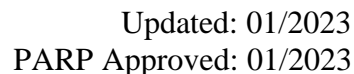
All requests for Relyvrio (sodium phenylbutyrate/taurursodiol) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Coverage may be provided with a diagnosis of **amyotrophic lateral sclerosis (ALS)** and the following criteria is met:

- Must be at least 18 years of age
- Must have a slow vital capacity (SVC) > 60% of predicted
- Must be able to perform activities of daily living (ADLs) such as eating and moving around independently
- Provide an ALSFRS-R score within the past 6 months
- Must be prescribed by or in consultation with a neurologist
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
 - Continues to experience clinical benefit based on the prescriber's assessment
 - Provide an ALSFRS-R score within the past 12 months
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.



Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Wholcare Pharmacy Services. **FAX:** (888) 245-2049

PROVIDER INFORMATION

MEMBER INFORMATION

REQUESTED DRUG INFORMATION

Billing Information

Place of Service Information

MEDICAL HISTORY (Complete for ALL requests)**ALSFRS-R Score:**

Is the member able to perform activities of daily living (ADLs) such as eating and moving around independently?

CURRENT or PREVIOUS THERAPY

REAUTHORIZATION

ALSFRS-R Score:

Prescribing Provider Signature

Date _____