

Updated: 01/2023

PARP Approved: 01/2023

## 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 **amyotropic 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
  - o Continues to experience clinical benefit based on the prescriber's assessment
  - o 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.



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## RELYVRIO (SODIUM PHENYLBUTYRATE/TAURURSODIOL) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation

as applical	ole to Highmark Wholecare P	harmacy Services. FA		
If needed, you may call to speak to			00) 392-1147 Mon – Fri 8:30am to 5:00pm	
	PROVIDER II	NFORMATION		
Requesting Provider:			Provider NPI:	
Provider Specialty:			Office Contact:	
State license #:			Office NPI:	
Office Address:			Office Phone:	
			Office Fax:	
MEMBER INFORMATION				
		DOB:		
· ·		Member weight:		
REQUESTED DRUG INFORMATION				
		Strength:	Ÿ	
Directions:		Quantity:	Refills:	
Is the member currently receiving requested medication?  Yes No Date Medication Initiated:			Medication Initiated:	
Billing Information				
This medication will be billed:   at a pharmacy OR medically, JCODE:				
Place of Service: Hospital Provider's office Member's home Other				
Place of Service Information				
Name:		NPI:	NPI:	
Address:		Phone:	Phone:	
MEDICAL HISTORY (Complete for ALL requests)				
Diagnosis:		ICD Code:		
ALSFRS-R Score:				
Forced vital capacity (FVC):	%			
Is the member able to perform activities of daily living (ADLs) such as eating and moving around independently?				
Yes No  CURRENT or PREVIOUS THERAPY				
			G	
Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)	
REAUTHORIZATION				
Has the member experienced clinical benefit with treatment?				
ALSFRS-R Score:				
SUPPORTING INFORMATION or CLINICAL RATIONALE				
Prescribing Provider Signature Date				