### Please fax all pages of completed form to your team at 808.650.6487.

To reach your team, call toll-free 808.650.6488.

You can now monitor shipments and chat online if you have questions. Go to <u>MyAccredoPatients.com</u> to log in or get started.

### Prescription & Enrollment Form Ocaliva<sup>®</sup> (obeticholic acid)



### Four simple steps to submit your referral.

## **1** Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

New patient Current p	atient		
Patient's first name		Last name	Middle initial
Preferred patient first name _		Preferred p	atient last name
Sex at birth: Male Fema	le Gender identity	Pronouns	Last 4 digits of SSN
Date of birth	Street address		Apt #
City		_ State	Zip
Home phone	Cell phone	E	mail address
Parent/guardian (if applicable)	l		
Home phone	Cell phone	E	mail address
Alternate caregiver/contact			
Home phone	Cell phone	E	mail address
OK to leave message with a	Iternate caregiver/contact		
Patient's primary language:	English Other If other, p	lease specify	

## 2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date	Time	Date medication needed	
Office/clinic/institution name			
Prescriber's first name		Last name	
Prescriber's title		If NP or PA, under direction of Dr	
Office phone	Fax	NPI #	License #
Office contact and title		Office contact email	
Office street address			Suite #
City			
Deliver product to: Prescriber's of			

# **3** Clinical Information

#### Primary ICD-10 code (REQUIRED):

NKDA	Known drug allergies		
Concurrent meds			
Child-Pugh C	lass*:		

Patient's first name	Last name	Middle initial	Date of birth
Prescriber's first name	Last name	Phone	

### **4** Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/Refills
Ocaliva <sup>®</sup> (obeticholic acid)	5mg tablets 10mg tablets	Therapy initiation:   Take one 5mg tablet daily with or without food for the first 3 months   Maintenance dose*:   Take one 5mg tablet every other day with or without food   Take one 5mg tablet once daily with or without food   Take one 10mg tablet once daily with or without food   *For patients who have not achieved adequate reduction in ALP and/or total bilirubin after first 3 months and who are tolerating Ocaliva®, increase to a maximum dose of 10mg once daily.	1-month supply 3-month supply Other Refills
Other	_		

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

I also certify that I understand OCALIVA<sup>®</sup> is contraindicated in patients with decompensated cirrhosis (e.g., Child-Pugh B or C) or a prior decompensation event, with compensated cirrhosis who have evidence of portal hypertension, or with complete biliary obstruction according to the Full Prescribing Information. In addition, I understand that hepatic decompensation and failure, sometimes fatal or resulting in liver transplant, has been reported with OCALIVA<sup>®</sup> treatment in primary biliary cholangitis (PBC) patients with either compensated or decompensated cirrhosis. Understanding this and other information contained in the Full Prescribing Information, I have determined that OCALIVA<sup>®</sup> is appropriate for this patient.

#### Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE				
HERE	Date	Dispense as written	Date	Substitution allowed

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.



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