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 MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

Ocaliva® (obeticholic acid)

accredo®
677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

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 patient

Patient's first name _____ Last name _____ Middle initial _____

Preferred patient first name _____ Preferred patient last name _____

Sex at birth: ☐ Male ☐ Female Gender identity _____ Pronouns _____ Last 4 digits of SSN _____

Date of birth _____ Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ Email address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ Email address _____

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other If other, please 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 _____ State _____ Zip _____

Deliver product to: ☐ Prescriber's office ☐ Patient's home

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____

☐ NKDA ☐ Known drug allergies _____

Concurrent meds _____

Child-Pugh Class*: _____

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® (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® 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® 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® is appropriate for this patient.

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

SIGN 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.

accredo®