Please fax all pages of completed form to your team at 888.302.1028.

To reach your team, call toll-free 888.608.9010.

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)

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®

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