



**Chenodal™ Prior Authorization Request Form**

**Please fax the completed request form to Mercy Health Plans Pharmacy Department  
at 314-214-8201 or 800-647-2240. For additional information please call 314-214-8282 or 800-647-2240.**

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Patient Pharmacy ID: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (located on bottom right of insurance card)  
 Requesting Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_  
 (Please print)  
 Office Contact Person: \_\_\_\_\_ Phone #: (\_\_\_\_)\_\_\_\_-\_\_\_\_ ext \_\_\_\_  
 Office Address: \_\_\_\_\_  
 Medication/Dose Requested: \_\_\_\_\_ Fax #: (\_\_\_\_)\_\_\_\_-\_\_\_\_  
 Expected Duration of Therapy: \_\_\_\_\_ ICD-9: \_\_\_\_\_

Please mark as applicable:		
1. Does the patient have cholesterol-type gallstones?	YES	NO
<input type="checkbox"/> Is the patient over 18 years of age?	YES	NO
<input type="checkbox"/> Has the patient tried and failed two years of generic Actigall (ursodiol) therapy?	YES	NO
<input type="checkbox"/> Is the patient able to undergo surgery for treatment?	YES	NO
2. Is this an initiation of therapy or a continuation of therapy?	NEW	CONTINUATION
For continued use, please submit hepatic function tests with this request.		

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_