



Pharmacy Request for Prior Approval - Cystic Fibrosis Medications

Recipient Information

1. Recipient Last Name: _____ 2. First Name: _____
 3. Recipient ID #: _____ 4. Recipient Date of Birth: _____ 5. Recipient Gender: _____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: Health Choice:

Prescriber Information

7. Prescribing Provider #: _____ NPI: or Atypical:

8. Prescriber DEA #: _____

Requester Contact Information

Name: _____ Phone #: _____ Ext: _____

Drug Information

9. Drug Name: Kalydeco Orkambi 10. Strength: _____ 11. Quantity Per 30 Days: _____

12. Length of Therapy (in days): up to 30 60 90 120 180 365 Other: _____

Clinical Information

For coverage of Kalydeco

1. Does the beneficiary have a diagnosis of Cystic Fibrosis? Yes No

2. Is the beneficiary age 2 or greater? Yes No

3. Does the beneficiary have a documented G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, S549R, R117H, E56K, K1060T, P67L, E193K, A1067T, R74W, L206W, G1069R, D110E, R347H, D579G, R1070Q, D1270N, D110H, R352Q, S945L, R1070W, R117C, A455E, S977F, F1074L, F1052V, or D1152H mutation in the CFTR gene? Yes No (Documentation must accompany this prior approval request)

4. Is the total daily dose prescribed 300mg/day total or less? Yes No

5. Did the beneficiary have a baseline ALT and AST assessed prior to beginning therapy? Yes No

Please list ALT and AST results and date labs were done.

5a. ALT level: _____ (U/L) 5b. Date: _____ 5c. AST level: _____ (U/L) 5d. Date: _____

For coverage of Orkambi

6. Does the beneficiary have a diagnosis of Cystic Fibrosis? Yes No

7. Is the beneficiary age 6 or greater? Yes No

8. Is the beneficiary documented as homozygous for the F508del mutation in the CFTR gene? Yes No

9. Will the beneficiary receive a dose of two tablets (each containing lumacaftor 200mg / ivacaftor 125mg) or less taken orally every 12 hours with fat containing food? Yes No

10. Did the beneficiary have a baseline ALT and AST assessed prior to beginning therapy? Yes No

Please list ALT and AST results and date labs were done.

10a. ALT level: _____ (U/L) 10b. Date: _____ 10c. AST level: _____ (U/L) 10d. Date: _____

Signature of Prescriber: _____ Date: _____

*Prescriber signature mandatory

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: (877) 386-4695

Pharmacy PA Call Center: (833) 585-4309