Cystic Fibrosis Drugs
Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004 or Provider Help Desk at 1-800-454-3730.

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #:_____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	Specify: _____
7. Diagnosis: _____			

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization (PA) is required for oral cystic fibrosis agents. Payment will be considered for patients when the following criteria are met:
1) Patient meets the FDA approved age; and
2) Patient has a diagnosis of cystic fibrosis (CF); and
3) Patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene confirmed by an FDA-cleared CF mutation test (attach test results) for which the requested drug is indicated; and
4) Prescriber is a CF specialist or pulmonologist; and
5) Baseline liver function tests (AST, ALT, and bilirubin) are provided; and
6) Requests for Trikafta will not be considered for patients with severe hepatic impairment (Child-Pugh Class C);and
7) Will not be used with other CFTR modulator therapies

If the criteria for coverage are met, an initial authorization will be given for six months. Additional approvals will be granted if the following criteria are met:

1) Adherence to oral cystic fibrosis therapy is confirmed; and
2) Liver function tests (AST, ALT and bilirubin) are assessed every three months during the first year of treatment and annually thereafter.

Non-Preferred
□ Kalydeco □ Orkambi □ Symdeko □ Trikafta

Diagnosis (attach copy of FDA-cleared CF mutation test results): _____
Attach copy of baseline liver function test (AST/ALT/bilirubin).
Prescriber specialty: □ CF Specialist □Pulmonologist □Other (specify): _____

Will requested medication be used with other CFTR modulator therapies? □ No □Yes

Trifakta requests:
Does patient have severe hepatic impairment (Child-Pugh Class C)? □ No □ Yes

Renewal requests:
Patient is adherent to oral cystic fibrosis therapy: □Yes □No

Liver function tests (AST/ALT/bilirubin) are assessed every 3 months during first year of treatment and annually thereafter: □ Yes □ No Most recent lab date: _____

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____
Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.