https://providers.amerigroup.com

Orkambi™ (Lumacaftor/Ivacaftor)
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.
Provider Help Desk: 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**
Orkambi	_____	_____	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 is required for Orkambi™ (lumacaftor/ivacaftor). Dual therapy with another cystic fibrosis transmembrane conductance regulator (CFTR) potentiator will not be considered. Payment will be considered for patients when the following criteria are met: 1) Patient meets the FDA approved age; and 2) Has a diagnosis of cystic fibrosis; and 3) Patient is homozygous for the F508del mutation in the CFTR gene as confirmed by a FDA-cleared CF mutation test; and 4) Baseline liver function tests (AST/ALT) and bilirubin levels are provided; and 5) Prescriber is a CF specialist or pulmonologist. If the criteria for coverage are met, an initial authorization will be given for 3 months. Additional approvals will be granted for 6 months at a time if the following criteria are met: 1) Adherence to lumacaftor/ivacaftor therapy is confirmed; and 2) Liver function tests (AST/ALT) and bilirubin are assessed every 3 months during the first year of treatment and annually thereafter.

☐ Orkambi
- Dosage instructions: _____
- Quantity: _____
- Days' supply: _____

Initial requests
Attach the following test results:
☐ FDA-cleared CF mutation test documenting patient is homozygous for the F508del mutation in the CFTR gene.
☐ Baseline liver function tests (AST/ALT) and bilirubin
- Result: _____

Prescriber specialty: ☐ CF Specialist ☐ Pulmonologist ☐ Other (specify): _____

Attach lab results and other documentation as necessary. Minimal required results to be submitted are the results of the gene mutation test and lab results.

Renewal requests.
Is patient adherent to Orkambi? ☐ Yes ☐ No

Liver function tests (AST/ALT) and bilirubin will be assessed every 3 months during the first year of treatment and annually thereafter? ☐ Yes (attached most recent results) Date and result: _____ ☐ No

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.