AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Cystic Fibrosis Medications (Kalydeco, Orkambi, Symdeko, and Trikafta)

Beneficiary Information

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

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other: _____

Clinical Information

Requests for Kalydeco:

1. Does the beneficiary have a diagnosis of cystic fibrosis? Yes___ No___
2. Is the beneficiary 1 month of age or older? Yes___ No___
3. Does the beneficiary have a documented mutation in the CFTR gene that is responsive to ivacaftor? Yes___ No___
4. If the beneficiary's genotype is unknown, has an FDA-cleared CF mutation test been used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instruction? Yes___ No___
5. Does the beneficiary have CF with homozygous for F508del mutation in the CFTR gene? Yes___ No___
6. Is the total daily dose prescribed 300mg/day or less? Yes___ No___
7. Did the beneficiary have a baseline ALT and AST assessed prior to beginning therapy? Yes___ No___
   ALT Result and Date: _____ **AST Result and Date:** _____

Requests for Orkambi:

8. Does the beneficiary have a diagnosis of cystic fibrosis? Yes___ No___
9. Is the beneficiary 1 years of age or older? Yes___ No___
10. Is the beneficiary documented as homozygous for the F508del mutation in the CFTR gene? Yes__ No___
11. If the beneficiary's genotype is unknown, has an FDA-cleared CF mutation test been used to detect the presence of the F508del mutation on both alleles of the CFTR gene? Yes___ No___
12. 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___
13. Did the beneficiary have a baseline ALT and AST assessed prior to beginning therapy? Yes___ No___
    ALT Result and Date: _____ **AST Result and Date:** _____

Requests for Symdeko:

14. Does the beneficiary have a diagnosis of cystic fibrosis? Yes___ No___
15. Is the beneficiary 6 years of age or older? Yes___ No___
16. Is the beneficiary documented as homozygous for the F508del mutation in the CFTR gene or have one mutation in the CFTR gene that is responsive to tezacaftor/ivacaftor? Yes___ No___
17. If the beneficiary's genotype is unknown, has an FDA-cleared CF mutation test been used to detect the presence of the F508del mutation on both alleles of the CFTR gene? Yes___ No___
18. Will the beneficiary receive 1 tablet in the morning and 1 tablet in the evening? Yes___ No___
19. Did the beneficiary have a baseline ALT and AST assessed prior to beginning therapy? Yes___ No___
    ALT Result and Date: _____ **AST Result and Date:** _____

Requests for Trikafta:

20. Does the beneficiary have a diagnosis of cystic fibrosis? Yes___ No___
21. Is the beneficiary 2 years of age or older? Yes___ No___
22. Is the beneficiary documented to have at least one copy of the F508del mutation in the CFTR gene? Yes___ No___
23. Does the beneficiary have one confirmed mutation in the CFTR gene that is responsive to elexacaftor/tezacaftor/ivacaftor? Yes___ No___
24. If the beneficiary's genotype is unknown, has an FDA-cleared CF mutation test been used to confirm the presence of at least one F508del mutation? Yes__ No___
25. Will the beneficiary receive a total daily dose of two tablets (elexacaftor 100 mg, tezacaftor 50 mg and ivacaftor 75 mg) in the morning and one tablet (ivacaftor 150 mg) in the evening? Yes___ No___
26. Did the beneficiary have a baseline ALT, AST, and bilirubin assessed prior to beginning therapy? Yes___ No___
    ALT Result and Date: _____ **AST Result and Date:** _____ **Bilirubin Result and Date:** _____
27. If the beneficiary is less than 18 years of age, has a baseline ophthalmic examination been performed? Yes___ No___

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: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406