



**MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM**

CFTR Modulators - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Member Name:	Prescriber Name:	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare Advantage	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

**Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.**

<p>Q1. Is the drug being prescribed by or in consultation with a pulmonologist, endocrinologist, or pediatrician?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q2. Does the patient have a confirmed diagnosis of cystic fibrosis?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q3. Has appropriate genetic testing been conducted? Appropriate lab work must be attached.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. For Kalydeco: Does genetic testing show the patient has one mutation in the CFTR gene that is responsive to ivacaftor based on clinical and/or in vitro assay data?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. For Orkambi: Does genetic testing show the patient is homozygous for the F508del mutation in the CFTR gene?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



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Member Name:	Prescriber Name:
Q6. For Trikafta: Does genetic testing show the patient has at least one F508del mutation in the CFTR gene or a mutation in the CFTR gene that is responsive based on in vitro data?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. Has baseline liver function (including alanine aminotransferase [ALT], aspartate aminotransferase [AST] and bilirubin) been assessed prior to initiation of treatment? Labs must be attached.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Requested Duration:	
<input type="checkbox"/> 12 months <input type="checkbox"/> Other	
Q9. Additional Information:	

Prescriber Signature

Date

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