Cystic Fibrosis CFTR Modulators

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval (at least one of the following criteria must be met):

- ❑ Medication is prescribed by or in consultation with a pulmonary specialist.
- ❑ Patient is managed by a Cystic fibrosis clinic. Clinic Name: _____
  Details if not managed by a CF clinic: _____
- ❑ Patient is adherent to evidence-based inhaled and oral therapies for pulmonary cystic fibrosis.
- ❑ Baseline FEV1. Chart note page #: _____
- ❑ Include a copy of the CF mutation laboratory test. List CFTR gene mutation: _____

Additional Criteria for Kalydeco (ivacaftor):

- ❑ Patient is at least 1 month old.

Additional Criteria for Orkambi (lumacaftor-ivacaftor):

- ❑ Patient is at least 1 year old.
- ❑ Laboratory confirmed CF, HOMOZYGOUS F508del mutation of the CFTR gene. Chart note page #: _____

Additional Criteria for Symdeko (tezacaftor-ivacaftor):

- ❑ Patient is at least 6 years old.
- ❑ Laboratory confirmed CF, HOMOZYGOUS F508del mutation of the CFTR gene. Chart note page #: _____

Additional Criteria for Trikafta (ivacaftor-tezacaftor-elexacaftor):

- ❑ Patient is at least 2 years old.
- ❑ Laboratory confirmed CF and at least one F508del mutation of the CFTR gene. Chart note page #: _____

Non-Preferred Product: *(Criteria above must also be met)*

- ❑ Trial and failure of preferred CFTR Modulator, per Utah Medicaid's PDL, or prescriber must demonstrate medical necessity for non-preferred product. Details: _____
  Chart Note Page #: _____

Re-authorization Criteria:
Updated letter of medical necessity or updated chart notes demonstrating improved FEV1 from baseline.

Initial Authorization: Up to six (6) months
Re-authorization: Up to one (1) year

Note:

- ❖ Co-administrations with CYP3A inducers are not recommended.
- ❖ Hepatic function should be assessed by liver function lab test prior to initiating treatment, every 3 months during the first year of treatment, and annually thereafter.
- ❖ Cataracts: Baseline and follow-up examinations are recommended in pediatric patients initiating treatment.

PROVIDER CERTIFICATION
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____
Prescriber's Signature Date