FAX Completed Form To
1.877.386.4695

Provider Help Desk
1.866.399.0928

Request for Prior Authorization
LUMACAFTOR/IVACAFTOR (ORKAMBI™)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

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 (attach most recent results) Date and result:_____ ☐ No

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*