FAX Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/
prior-authorization-forms/

Request for Prior Authorization
CYSTIC FIBROSIS AGENTS, ORAL
(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 (PA) is required for oral cystic fibrosis agents. Payment will be considered for patients when the following criteria are met:

1) **Patient meets the FDA approved age; and**
2) **Patient has a diagnosis of cystic fibrosis (CF); and**
3) **Patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene confirmed by an FDA-cleared CF mutation test (attach test results) for which the requested drug is indicated; and**
4) **Prescriber is a CF specialist or pulmonologist; and**
5) **Baseline liver function tests (AST, ALT, and bilirubin) are provided; and**
6) **Requests for Trikafta will not be considered for patients with severe hepatic impairment (Child-Pugh Class C); and**
7) **Will not be used with other CFTR modulator therapies.**

If the criteria for coverage are met, an initial authorization will be given for 6 months. Additional approvals will be granted if the following criteria are met:

1) **Adherence to oral cystic fibrosis 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.**

Non-Preferred

☐ Kalydeco ☐ Orkambi ☐ Symdeko ☐ Trikafta

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis (Attach copy of FDA-cleared CF mutation test results): _____

Attach copy of baseline liver function test (AST/ALT/bilirubin).

Prescriber Specialty: ❑ CF Specialist ❑ Pulmonologist ❑ Other (specify): _____

FAX Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/
prior-authorization-forms/

Request for Prior Authorization
CYSTIC FIBROSIS AGENTS, ORAL
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Will requested medication be used with other CFTR modulator therapies? ☐ No ☐ Yes

Trifakta Requests:

Does patient have severe hepatic impairment (Child-Pugh Class C)? ☐ No ☐ Yes

Renewal Requests:

Patient is adherent to oral cystic fibrosis therapy: ☐ Yes ☐ No

Liver function tests (AST/ALT/bilirubin) are assessed every 3 months during first year of treatment and annually thereafter: ☐ Yes ☐ No Most recent lab date: _____

Attach lab results and other documentation as necessary.

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.*