PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Orkambi

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department 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 left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What diagnosis is this drug being prescribed for?

☐ Cystic Fibrosis ☐ Other (Please Specify)

Q2. Please provide ICD code(s) for diagnosis

Q3. Please provide most recent chart note, labs, genotype testing, and any other clinical information that may be useful for the pharmacist and medical director reviewing the request. Coverage will not be approved without documentation to confirm all criteria are met.

Q4. Is patient a NEW START to Orkambi therapy?

☐ Yes ☐ No - specify start date

Q5. Does patient have a confirmed homozygous F508del mutation on the CFTR gene using an FDA-approved test?

☐ Yes ☐ No

Q6. Please select all that apply regarding labs and provide documentation:

☐ AST/ALT < 5 x ULN

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☐ AST/ALT < 3 x ULN if bilirubin is > 2 x ULN
☐ None of the above

Q7. If the patient is less than 18 years of age, has patient had a baseline and, if applicable, follow up ophthalmic exam(s) to check for lens opacities and cataracts?

☐ Yes
☐ No
☐ N/A (Patient >18 years)

Q8. If the patient is a female of child-bearing age, is a non-hormonal form of contraception being used?

☐ Yes ☐ No ☐ N/A

Q9. Will the patient be taking any of the following medications along with Orkambi? (Select all that apply)

☐ Kalydeco
☐ Symdeco
☐ Strong CYP3A4 inducers (e.g. barbiturates, carbamazepine, efavirenz, glucocorticoids, modafinil, nevirapine, oxcarbamazepine, phenobarbital, phenytoin, pioglitazone, rifabutin, St. John's Wort)
☐ None of the Above

Q10. If request is for CONTINUATION of therapy, is patient's FEV1 stable or has it improved since initiation of Orkambi therapy?

☐ Yes ☐ No

Q11. If request is for CONTINUATION of therapy, does patient have a documented clinical improvement since initiation of Orkambi therapy?

☐ Yes ☐ No

Q12. Additional Comments

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Prescriber Signature _____ Date _____

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.