Prior Authorization Form
Cystic Fibrosis Agents

Access this PA form at: Forms | OptumRx

If the following information is not complete, correct, or legible, the PA process can be delayed. Use one form per member please.

Member Information (required)			**Prescriber Information (required)**		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	DEA #:	
Date of Birth:			Specialty:		
Street Address:			Office Phone:	Office Fax:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
			Is the prescriber a Tenncare provider with a Medicaid ID? ☐ Yes ☐ No Is the prescriber a single-patient contract holder for this patient? ☐ Yes ☐ No		

REQUESTED Cystic Fibrosis Agents: CFTR Potentiators					
☐**Alyftrek®**	☐**Kalydeco®**	☐ **Orkambi®**	☐ **Symdeko®**	☐ **Trikafta®**	**STRENGTH:**
DIRECTIONS:					**QUANTITY:**
PLEASE INDICATE: ☐ Initial Request (**NOTE:** INITIAL PA DURATION MAY NOT EXCEED 6 MONTHS)				☐ Renewal Request	

Clinical Criteria Documentation ******* DO NOT** include documentation that is not requested on this form *****

PLEASE INDICATE THE DIAGNOSIS FOR WHICH THIS DRUG IS BEING REQUESTED?

1. Patient has a diagnosis of Cystic Fibrosis (CF) ☐Yes ☐No
2. Is the agent prescribed or in consultation with a provider at a Cystic Fibrosis Center of Excellence or pulmonologist? ☐Yes ☐No

(Renewal Requests skip to Question 7)

3. Patient has a CFTR gene mutation ☐Yes ☐No

   3a. Please indicate patient's CFTR gene mutation:

   ☐ G551D ☐ G1244E ☐ G1349D ☐ G178R
   ☐ G551S ☐ S1251N ☐ S1255P ☐ S549N
   ☐ S549R ☐ R117H ☐ Homozygous F508del ☐ Other – Please list: _____

4. Has patient received a baseline FEV1? ☐Yes ☐No
5. For patients aged 2-12 years, has the patient received a baseline ophthalmic examination? ☐Yes ☐No
6. Please note of any other information pertinent to this PA request:

For <u>Renewal</u> Requests ONLY (complete question 7 and 8):

7. Has patient received a lung transplant? ☐Yes ☐No
   a. If yes, does the prescriber attest the patient continues to experience non-pulmonary CF related symptoms (e.g., sinus, gastrointestinal, diabetes, pancreatic). ☐Yes ☐No

8. Has the patient had improvement in FEV1, pulmonary exacerbations, or BMI receiving since the requested agent? ☐Yes ☐No
   Please indicate which clinical market improved for the patient:

   (If the response is "yes" to any of the following clinical markers below, please provide documentation of the improvement.)

   8a. Stable or improved FEV1 ☐Yes ☐No

   8b. Decreased pulmonary exacerbations compared to pretreatment baseline ☐Yes ☐No

   8c. Improvement in BMI compared to pretreatment baseline ☐Yes ☐No

_____ _____

Prescriber Signature (required) **Date**

(By signature, the Physician confirms the above information is accurate and verifiable by patient records)

Fax this form to: 1-866-434-5523
Phone: 1-866-434-5524
OptumRx will provide a response within 24 hours upon receipt.