Trikafta (elexacaftor/tezacaftor/ivacaftor) Prior Authorization Request Form

Caterpillar Prescription Drug Benefit

Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA. ☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	**DURATION OF THERAPY** (SPECIFY DATES):	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Cystic fibrosis ☐ Other diagnosis: _____ ICD-10 Code(s): _____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Is the drug requested a part of a clinical trial? ☐ Yes ☐ No

FOR ALL (INITIAL AND RENEWAL) REQUESTS:

Is this patient HOMOZYGOUS for the F508del CFTR mutation? ☐ Yes ☐ No Test documentation must be provided

Is this patient HETEROZYGOUS for the F508del CFTR mutation? ☐ Yes ☐ No Test documentation must be provided

If patient is HETEROZYGOUS for the F508del, please also answer the following:

Is the patient's OTHER (non-F508del) mutation currently listed within the FDA package insert for Trikafta?

☐ Yes ☐ No *Test documentation must be provided*

FOR INITIAL REQUESTS ONLY:

For patients age 12 years and older: Is patient's FEV1 40-90% inclusive, obtained while the patient is NOT receiving treatment with Trikafta or any other CFTR medication (Kalydeko,Orkambi or Symdeko)? ☐ Yes ☐ No

Please submit this documentation from patient's chart.

For patients age 6 to 11 years: Is patient's FEV1 40% or greater, obtained while the patient is NOT receiving treatment with Trikafta or any other CFTR medication (Kalydeko,Orkambi or Symdeko)? ☐ Yes ☐ No

Please submit this documentation from patient's chart.

FOR RENEWAL REQUESTS ONLY:

You must answer ALL of the following questions.

Is this request for renewal of therapy (meaning the patient is currently receiving therapy with Trikafta)?

☐ Yes ☐ No

Is documentation available which shows the patient's current FEV1 percentage of predicted measurement?

☐ Yes ☐ No

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Current FEV1 percentage of predicted measurement is defined as the most recent FEV1 percentage of predicted that was measured* between 4-12 weeks AFTER initiating and while the patient is receiving treatment with *Trikafta.

Please submit this documentation, such as chart notes.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909