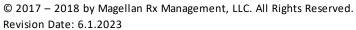




Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME:		MEMBER'S FIRST NAME:	
	, chart notes or lab data, to s	ely and legibly. Attach any add support the authorization requ	
tilis form is r forceted freditiff	mormation under rin AA.		☐ URGENT
MEMBER INFORMATION			
LAST NAME:		FIRST NAME:	
PHONE NUMBER:		DATE OF BIRTH:	
STREET ADDRESS:			
CITY:		STATE: ZIP CODE:	
PATIENT INSURANCE ID NU	MBER:	-1	
☐ MALE ☐ FEMALE HEIG	GHT (IN/CM): WEIC	GHT (LB/KG): ALLERG	GIES:
		CLOSURE AUTHORIZATION FORM WITH THIS REC	
		E):	
AUTHORIZED REPRESENTATI	VE'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	N	
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
☐ NEW THERAPY	RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPE	ECIFIC DATES):		
. (5: 5			

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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:			
1. HAS THE PATIENT TRIED ANY OTHER	R 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:IC	D-10 Code(s):			
3. REQUIRED CLINICAL INFORMATION PRIOR AUTHORIZATION.	N: PLEASE PROVIDE ALL RELEVANT CLIN	ICAL INFORMATION TO SUPPORT A		
Clinical Information: Is the drug requested a part of a clinical trial? Yes No Is this request for initial therapy (meaning the patient has not received therapy with Kalydeco in the past AND there are no paid claims for Kalydeco in member's history)? Yes No If No, please complete "Renewal Therapy" section below. 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: If patient is under the age of 6 years, please answer the following:				
Documentation must be provided. □ Infant Pulmonary Function Test(IPF	sis(CF) exacerbations requiring antibio			
If patient is 6 years of age or older, please answer the following: 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)? Please submit this documentation from patient's chart.				
FOR RENEWAL REQUESTS ONLY: You must answer ALL of the following	g questions.			

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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:
Is this request for renewal of therapy (meaning	ng the patient is currently receiving therapy AND paid
claims are in member's history)? 🗆 Yes 🗆 No	0
Note: use of samples only and/or access th	rough patient assistance program only does not qualify as current
therapy subject to renewal; those should be	e submitted as initial therapy instead.
If No, please complete "Initial Therapy" section	n above.
Has patient had a lung transplant? ☐ Yes ☐ N	No
For patients under 6 years of age, please ans	wer the following:
Does patient have a disease response as indicated documentation, e.g., chart notes	ated by one or more of the following: Yes No Please submit this
☐ Decreased pulmonary exacerbations compa	ared to pre-treatment baseline
 □ Decrease in decline of lung function as mea Trikafta(elexacaftor/tezacaftor/ivacaftor) 	sured by percent predicated FEV1 from date of start of
☐ Improvement in quality of life demonstrate	d by at least 2 of the following:
☐ Cystic Fibrosis Questionnaire-Revised Sc	ore(CFQ-R)
□ Weight gain	
□ Increase in height.	
For patients 6 years of age or older, please ar	nswer the following
	patient's current FEV1 percentage of predicted measurement?
□ Yes □ No	was and in defined as the most recent FFV/4 necessary of musting
	rurement is defined as the most recent FEV1 percentage of predicted FTER initiating and while the patient is receiving treatment with such as chart notes.
Are there any other comments, diagnoses, sy	nptoms, medications tried or failed, and/or any other information the
physician feels is important to this review?	inploins, medications thed of falled, and of any other information the
Please note: Not all drugs/diagnosis are covere	ed on all plans. This request may be denied unless all required
information is received.	
· · · · · · · · · · · · · · · · · · ·	ed is true and accurate to the best of my knowledge. I understand that
	lesignees 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. Verificat	ion: Date:



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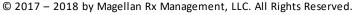
MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:

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FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program

Attn: CP – 4201 P.O. Box 64811 St. Paul, MN 55164-0811



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