OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

Drug Requested: Orkambi® (ivacaftor/lumacaftor) ***RE-AUTHORIZATION FORM***

***DRUG INFORMATION:** Complete information below. If incomplete, authorization process will be delayed.*

Drug Form/Strength: ____

Dosing Schedule: ______________________________ **Length of Therapy:** ____________________

Diagnosis: ____________________________________ ***ICD Code, if applicable:*** ______________

Number of hospitalization (ICD 277-00-277.09) will be defined by ICD.

Orkambi® will not be covered for patients with $FEV_1 \geq 90$ % initiation.

***CLINICAL CRITERIA:** Check applicable boxes below. To qualify, all boxes must be checked or authorization process will be delayed. Must attach ALL documentation/progress notes/lab results AND be compliant.*

- ***Re-Approval will be based on all THREE (3) of the following:***
  - ❑ Has the member Body weight increased at least 1.5kg? ❑ Yes **or** ❑ No
  - ❑ Has the FEV1 ≥ 5%? ❑ Yes **or** ❑ No
  - ❑ Has hospitalization decrease since prior to Orkambi therapy? ❑ Yes **or** ❑ No
  - ❑ **Send Lab results documenting the following *(must be attached)*:**
    - ❑ Recent LFTs (within the last months)
    - ❑ Patient does not have positive cultures for Burkholderia cencopacia, Burkholderia dolosa, or Mycobacterium abscessus. ***Lab documentation required within last six (6) months of THIS request.***
  - ❑ **Member is currently COMPLIANT on *at least TWO (2)* of the following:**
    - ❑ Dornase alfa
    - ❑ Hypertonic saline
    - ❑ Inhaled or oral antibiotics within the last 3 months

Baseline Date (***PRIOR to Orkambi***®): ____________________	Re-Authorization Date: ____________________
FEV1 Baseline (***last FEV1 prior to Orkambi***®): ____________________	FEV1 reauthorization (***FEV1 AFTER last dose of Orkambi***®): ____________________
Baseline Weight: ____________________	Re-Authorization Weight: ____________________
BMI baseline: ____________________	BMI Re-authorization: ____________________
Please note the number of hospitalization while on Orkambi® will be evaluated. ____________________	
While on Orkambi®, has IV/po antibiotics changed >3 times? ❑ Yes ❑ No	

(signature on next page)

Medication being provided by a Specialty Pharmacy - Sentara Norfolk General CM Pharmacy

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: ____

Member Optima #: ______________________________ Date of Birth: ________________

Prescriber Name: ____

Prescriber Signature: ______________________________ Date: ________________

Office Contact Name: ____

Phone Number: ______________________________ Fax Number: ________________

DEA OR NPI #: ____

***REVISED/UPDATED: 8/1/2018**