OPTIMA FAMILY CARE MEDALLION

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)

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:*** ______________

- ***Positive cultures for Burkholderia cencopacia, Burkholderia dolosa, or Mycobacterium abscessus will not be covered***
- ***Orkambi® will NOT be covered for patients with FEV_1 > 90 %.***

CLINICAL CRITERIA: ***ALL boxes below must be checked to qualify. Lab results and chart notes MUST be attached. If not included, authorization process will be delayed.***

- ❑ Patient is ***6 years of age or older*** with a diagnosis of Cystic Fibrosis.
- ❑ Patient is confirmed to be homozygous for the Phe-508del gene mutation of the CFTR protein ***(Lab documentation required)***
- ❑ Baseline FEV_1 (within the last 3 months). ***(Lab documentation required)***
- ❑ Recent eGFR or SCr (within the last 3 months) ***(Lab documentation required)***
- ❑ Recent LFTs (within the last 3 months) ***(Lab documentation required)***
- ❑ 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 three (3) months	

Initial Authorization Limit to 6 months.

For Re-authorization, member must show improvement from baseline of at least FEV1 5% and compliance

Baseline Date:______________________________***(prior to Orkambi® 1st dose)***

FEV1:______________________________

(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: 7/1/2018**