OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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 or 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 $\geq$ 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

(continue on next page)

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

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:** ~~1 8/26/2017;~~ **8/13/2018**