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)

DRUG INFORMATION: Complete information below or 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 c**overed
- 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 might 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:** ~~8/26/2017;~~ **8/29/2018**;