

OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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 FEV₁ ≥ 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: _____
FEV ₁ Baseline (last FEV₁ prior to Orkambi®): _____	FEV ₁ 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: † 8/26/2017**