OPTIMA HEALTH PLAN

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$_1$ ≥ 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	

(continued on next page)

Medication being provided by a Specialty Pharmacy: ❑ **Briova SpecialtyRx**

*****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 #: ____

***Approved by Pharmacy and Therapeutics Committee**: ~~11/17/2015;~~ 10/14/2016
REVISED/UPDATED: ~~1/18/2016; 1/27/2016; 2/5/2016; 3/30/2016; 6/6/2016; 6/30/2016; 8/11/2016; 9/27/2016; 11/17/2016; 12/8/2016; 12/21/2016; 9/11/2017;~~ **10/4/2017**