Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Orkambi® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Cystic fibrosis

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is the patient's forced expiratory volume in 1 second (FEV1) less than or equal to 90%? ❑ **Yes** ❑ **No**
Must provide labs and charts

Is the patient homozygous for the Phe-508del gene mutation of the CFTR protein? ❑ **Yes** ❑ **No**
Lab documentation required

Will the following labs (within the last 3 months) be provided: Baseline FEV1, recent eGFR or SCr, and recent LFTs? ❑ **Yes** ❑ **No**
Lab documentation required

Select if the patient is positive for any of the following cultures:
❑ Burkholderia cenocepacia ❑ Burkholderia dolosa ❑ Mycobacterium abscessus
Lab documentation required within last six (6) months of THIS request

Select if the patient is currently compliant on the following therapies:
❑ Dornase alfa (Pulmozyme) ❑ Hypertonic saline ❑ Inhaled or oral antibiotics within the last three (3) months

Reauthorization:
If this is a reauthorization, answer the following questions:

Has the patient's body weight increased at least 1.5 kg? ❑ **Yes** ❑ **No**
Must provide weight and BMI at baseline and at reauthorization

Has the patient had improvement in FEV1 by greater than or equal to 5%? ❑ **Yes** ❑ **No**
Must provide FEV1 at baseline with date and FEV1 at reauthorization with date

Has the patient had a decrease in hospitalization since prior to Orkambi therapy? ❑ **Yes** ❑ **No**
Must provide number of hospitalizations while on therapy

Please provide the patient's recent LFTs from within the last month:
AST: _____ Date: _____
ALT: _____ Date: _____
Must provide labs

Select if the patient is positive for any of the following cultures:
❑ Burkholderia cenocepacia ❑ Burkholderia dolosa ❑ Mycobacterium abscessus
Lab documentation required within last six (6) months of THIS request

Select if the patient is currently compliant on the following:
❑ Dornase alfa (Pulmozyme) ❑ Hypertonic saline ❑ Inhaled or oral antibiotics within the last three (3) months

Orkambi® Prior Authorization Request Form (Page 2 of 2)

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Medication being provided by: (Please check applicable box below)

❑ PropriumRx ❑ Specialty Pharmacy (specify name): _____

****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.

Prescriber Signature: _____ **Date:** _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.