Cystic Fibrosis Agents (Oral)

Please fax this completed form to (833) 645-2734 OR mail to: Pharmacy Services | 5 River Park Place East, Suite 210 | Fresno, CA 93720. You can also complete online at CoverMyMeds.com.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
   If yes, is there documentation showing any of the following? (check all that apply)
   ☐ Improvement in FEV1
   ☐ Decrease in the decline of lung function
   ☐ Decreased pulmonary exacerbations or infections
   ☐ Decreased hospitalizations
   ☐ Increased weight or growth

2. Indicate patient's diagnosis:
   ☐ Cystic Fibrosis
   ☐ Other. Specify:

3. Will the patient be taking the requested medication simultaneously with a CYP3A4 inducer? ☐ Yes ☐ No
   If yes, what CYP3A4 inducer patient will be taking?

4. Does patient have any of the following (check all that apply):
   ☐ At least one mutation in the CFTR gene that is responsive to ivacaftor (Kalydeco), tezacaftor/ivacaftor (Symdeko), or or elexacaftor/tezacaftor/ivacaftor (Trikafta)
   ☐ At least one F508del CFTR mutation for elexacaftor/tezacaftor/ivacaftor (Trikafta)
   ☐ Homozygous F508del CFTR mutation (2 copies) for lumacaftor/ivacaftor (Orkambi) or tezacaftor/ivacaftor (Symdeko)

5. Does patient have severe hepatic insufficiency (Child-Pugh class C)? ☐ Yes ☐ No

6. **For pediatric patients under 18 years of age:** Was there a baseline ophthalmic examination performed to monitor lens opacities/cataracts? ☐ Yes ☐ No

7. Is this prescribed by or in consultation with a provider who specializes in the treatment of cystic fibrosis? ☐ Yes ☐ No

CHART NOTES, CFTR GENE MUTATION TESTING AND LABS ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date

Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)