



**MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM**

CFTR Modulators

Phone: 215-991-4300

Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Member Name:	Prescriber Name:	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare Advantage	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

**Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.**

Q1. Is the drug being prescribed by or in consultation with a pulmonologist, endocrinologist, or pediatrician?

Yes No

Q2. Does the patient have a confirmed diagnosis of cystic fibrosis?

Yes No

Q3. Has appropriate genetic testing been conducted? Appropriate lab work must be attached.

Yes No

Q4. 4. For Kalydeco: Does genetic testing show the patient has one mutation in the CFTR gene that is responsive to ivacaftor based on clinical and/or in vitro assay data? For Orkambi: Does genetic testing show the patient is homozygous for the F508del mutation in the CFTR gene? For Trikafta: Does genetic testing show the patient has at least one variant in the CFTR gene that is either responsive based on clinical and/or in vitro data or results in production of CFTR protein?

Yes No



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Member Name:	Prescriber Name:
Q5. Has baseline liver function (including alanine aminotransferase [ALT], aspartate aminotransferase [AST] and bilirubin) been assessed prior to initiation of treatment? Labs must be attached. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q6. Requested Duration: <input type="checkbox"/> 12 months <input type="checkbox"/> Other	
Q7. Additional Information:	

Prescriber Signature

Date

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