Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**

This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Orkambi™ (lumacaftor/ivacaftor)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Drug information

☐ New request ☐ Continuation request

Product:
☐ Orkambi oral tablet
☐ Orkambi oral granules

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

For this drug to be covered, the patient must meet the following criteria:

1. Must be used for treatment of cystic fibrosis
2. Must be age 2 or older
3. Must have laboratory confirmation of the homozygous F508del mutation in the CFTR (cystic fibrosis transmembrane regulator) gene

Additional information

Note: When criteria are met, duration of approval will be for 1 year. Orkambi is limited to a quantity of 120 tablets or packets per 30 days.

Medically-accepted indication

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 01/2019
Last reviewed 09/2019

Priority Health Precertification Documentation

A. What is the patient's diagnosis?

- ☐ Cystic fibrosis
- ☐ *Other – the patient's condition is:* _____

Rationale for Other use: _____

A. Has laboratory confirmation of the homozygous F508del mutation in the CFTR gene been provided?

- ☐ Yes
- ☐ No. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: _____
  - ☐ No

Priority Health Medicare Exception Request *(exceptions to the above criteria)*

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Orkambi likely be the most effective option for this patient?

- ☐ No
- ☐ Yes, because: _____

If the patient is currently using Orkambi, would changing the patient's current regimen likely result in adverse effects for the patient?

- ☐ No
- ☐ Yes, because: _____

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