Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

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: _____

Product Information

☐ New request ☐ Continuation request

Drug product:

☐ Orkambi 100mg-125mg Granules
☐ Orkambi 150 mg-188mg Granules
☐ Orkambi 100mg-125mg tablet
☐ Orkambi 200mg-125mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Drug cost information

The wholesale acquisition cost for each Orkambi tablet is $186 and for each Orkambi Granule is $373. The annual cost of treatment with this drug is more than $270,000

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Must be used for treatment of cystic fibrosis (documentation of a cystic fibrosis ICD10 code* within the last 12 months must be submitted to Priority Health)
2. Must have laboratory confirmation of homozygous F508del mutation in the CFTR (cystic fibrosis transmembrane regulator) gene
3. Dose requested must match FDA label for age and weight.
4. Formulation requested must match FDA label for age (2 to 5 years for the oral packet and at least 6 years old for the oral tablet)

* Approved ICD10 codes are provided in the Additional Information section

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

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

Updated 09/2018
Last reviewed 09/2019

Priority Health Precertification Documentation

A. What is the patient's diagnosis?

☐ Cystic fibrosis (documentation of a cystic fibrosis ICD10 code from within the last 12 months must be submitted to Priority Health)

☐ *Other:* _____

Rationale for use: _____

B. Fax laboratory confirmation of homozygous F508del mutation in the CFTR gene.

Additional Information:

Approved ICD10 Codes for Cystic Fibrosis

ICD10	ICD10 Label
E84.0	Cystic fibrosis with pulmonary manifestations
E84.11	Meconium ileus in cystic fibrosis
E84.19	Cystic fibrosis with other intestinal manifestations
E84.8	Cystic fibrosis with other manifestations
E84.9	Cystic fibrosis, unspecified

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Updated 09/2018
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