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Montana Medicaid Prior Authorization Request Form for Use of Orkambi® (lumacaftor/ivacaftor)

Patient Name:	Date:
Patient Medicaid ID:	DOB:
Prescriber Name:	Specialty:
Prescriber Phone:	Prescriber Fax:

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ INITIATION OF THERAPY

- Patient is 2 years of age or older. ☐ Yes ■ No
- Laboratory results **are attached** confirming that patient is homozygous for the F508del mutation in the cystic fibrosis transmembrane regulator (CFTR) gene. ☐ Yes ■ No
- Prescriber is a pulmonologist specializing in the treatment of cystic fibrosis. ☐ Yes ■ No
- Provider attests current cystic fibrosis therapies have been optimized. ☐ Yes ■ No
- Provide baseline percent predicted expiratory volume (ppFEV$_1$): _____ Date: _____
- History of pulmonary exacerbations within the past 12 months is provided:

Initial authorization will be issued for 6 months.

☐ CONTINUATION OF THERAPY

- Date medication started: _____
- Provider attests that patient has been compliant on Orkambi® and other cystic fibrosis maintenance medications Yes ☐ No ☐ (***Note*: Verification of compliance will be made via Medicaid paid claims data. Non-compliance will result in non-authorization of renewal.**):
- Provider attests that in comparison to baseline, the patient has achieved a clinically meaningful response *while on Orkambi® therapy* to one or more of the following:
  - o Lung function improvement as demonstrated by improvement or stability in ppFEV$_1$. ☐ Yes ☐ No
    - Provide current ppFEV$_1$:_____ Date: _____
  - o Decline in pulmonary exacerbations. ☐ Yes ☐ No
  - o Stability or increase in body mass index (BMI). ☐ Yes ☐ No
- Prescriber is a pulmonologist specializing in the treatment of Cystic Fibrosis. ☐ Yes ☐ No

Reauthorization will be issued for 6 months.

Please complete form, including required attachments and fax to:
Medicaid Drug Prior Authorization Unit
1-800-294-1350