Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

Cystic Fibrosis Agents Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Cystic Fibrosis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Drug-Specific Information (required)

Kalydeco® (ivacaftor)

- ❑ The recipient is six months of age or older
- ❑ There is documentation that the recipient has had an FDA-approved cystic fibrosis mutation test confirming the presence of one of the gene mutations listed in the FDA-approved package insert (**please attach documentation to request**)
- ❑ The medication is prescribed by or in consultation with a pulmonologist or a specialist associated with a CF care center
- ❑ If the request is for continuation of therapy, the recipient has documentation of positive clinical response to Kalydeco® therapy

Orkambi® (lumacaftor/ivacaftor)

- ❑ The recipient is two years of age or older
- ❑ The recipient is homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CTFR) gene
- ❑ The dose is two tablets every 12 hours
- ❑ The dose is one tablet every 12 hours in the presence of severe hepatic impairment

Symdeko® (tezacaftor/ivacaftor)

- ❑ The recipient is six years of age or older
- ❑ The medication is prescribed by or in consultation with a pulmonologist or a specialist associated with a CF care center
- ❑ The recipient is homozygous for the F508del mutation as detected by an FDA cleared CF mutation test or CLIA approved facility
- ❑ The recipient has one of the FDA approved package insert listed mutations on at least one allele in the CF transmembrane conductance regulator (CFTR) gene as detected by FDA cleared CF mutation test or CLIA approved facility
- ❑ If the request is for continuation of therapy, the recipient has documentation of positive clinical response to Symdeko® therapy (e.g., improvement in lung function or decreased number of pulmonary exacerbations)

Trikafta® (elexacaftor/tezacaftor/ivacaftor and ivacaftor)

- ❑ The recipient is 12 years of age or older
- ❑ The recipient has at least one F508del mutation in the CFTR gene as detected by an FDA cleared CF mutation test or a test performed at a CLIA approved facility
- ❑ The medication is prescribed by or in consultation with a pulmonologist or a specialist associated with a CF care center
- ❑ If the request is for continuation of therapy, the recipient has documentation of positive clinical response to Trikafta® therapy (e.g., improvement in lung function [percent predicted forced expiratory volume in one second {PPFEV1}] or decreased number of pulmonary exacerbations)

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.