

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)				Provi	Provider Information (required)			
Member Name:			Provider Name:					
Insurance ID#:			NPI#:		Specialty:			
Da	Date of Birth:			Office Phone:	Office Phone:			
Street Address:			Office Fax:					
Cit	y:	State:	Zip:	Office Street Addre	ess:			
Ph	one:			City:		State:	Zip:	
			Modicatio	on Information (require	- 1		·	
Me	dication Name:		Medicalic	Strength:	ea)	Dosage	Form:	
☐ Check if requesting brand				Directions for Use:				
	Check if request is for cont	inuation of	therapy					
			Clini	cal Information (requ	ired)			
Se	lect the diagnosis belo	w:						
	Cystic Fibrosis							
	Other diagnosis:			ICD-10 Code(s)	:			
			Drug-Sr	ecific Information (required)			
			Drug Op		requireu			
	alvela a a 🖯 (ivea a stan)							
	alydeco® (ivacaftor)			- FDA compressed models of				
	The recipient is age appropriate according to the FDA-approved package labeling						nfirming the presenc	
_	There is documentation that the recipient has had an FDA-approved cystic fibrosis mutation test confirming the present of one of the gene mutations listed in the FDA-approved package insert (please attach documentation to request)							
	-			on with a pulmonologist of	·-		- '	
☐ If the request is for continuation of therapy, the red				-				
	therapy			·	·		•	
Oı	kambi® (lumacaftor/	ivacaftor						
	The recipient is age ap	propriate a	ccording to the	e FDA-approved packag	e labeling			
	The recipient is homozy	gous for tl	ne F508del mu	utation in the cystic fibros	sis transmembra	ane conduc	tanceregulator	
	(CTFR) gene							
Sy	mdeko® (tezacaftor/	ivacaftor)						
	The recipient is age ap	propriate a	ccording to the	e FDA-approved packag	e labeling			
	The recipient is homozy	gous for t	he F508del mi	utation as detected by ar	FDA cleared (CF mutation	test or CLIA	
	approved facility							
	·			kage insert listed mutation				
		ctance reg	ulator (CFTR)	gene as detected by FD	A cleared CF n	nutation test	t or CLIA approved	
	facility	tinuation o						
	11 1110 1040001 19 101 CON		f tharany that	recipient has documenta	tion of positive	clinical room	ones to Symdoko®	

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Tr	ikafta® (elexacaftor/tezacaftor/ivacaftor and ivacaftor)
	The recipient is age appropriate according to the FDA-approved package labeling
	The recipient has at least one F508del mutation in the CFTR gene or a mutation in the CFTR gene that is responsive
	based on in vitro data 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)
	there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to review?
Pleas	se note: This request may be denied unless all required information is received. For urgent or expedited requests please call 1-800-711-4555.

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