mercy care

Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/chp-forproviders/pharmacy

Cystic Fibrosis Medications
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone		Office Fax:

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information				
Preferred Agents:	☐ Bethkis	☐ Kitabis		
Non-preferred Agents:	☐ Cayston	☐ Kalydeco	☐ Pulmozyme	☐ Orkambi
	☐ Symdeko	☐ Tobramycin Nebulizer Sol	☐ Tobi Podhaler	☐ Trikafta

Are there any contraindications to formulary medications? (if yes, specify):	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy

☐ Continuation of Therapy for Non-Cystic Fibrosis Bronchiectasis (Tobramycin nebulizer solution OR Kitabis OR Tobi Podhaler OR Bethkis ONLY):	☐ Response to therapy	
☐ Continuation of Therapy for Kalydeco OR Symdeko OR Orkambi OR Trikafta ONLY):	☐ Response with improvement and/or stable FEV_1	☐ Pediatric members ONLY: Eye exam
	☐ ALT/AST monitoring	☐ D/C if ALT/AST >5 times ULN
	☐ ALT/AST >3 times ULN with bilirubin >2 times ULN	

Directions for Use:	Strength:		Dosage Form:
	Quantity:	Day Supply:	Duration of Therapy/Use:

Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No	Diagnosis:	ICD-10 Code:

What medication(s) have been tried and failed for this diagnosis? (please specify):

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information

☐ **Pulmozyme**

Does member have diagnosis of Cystic Fibrosis?	☐ Yes	☐ No	Is member at least 5 years of age?	☐ Yes	☐ No

☐ **Tobramycin Nebulizer Solution - Generic for Tobi**

Are sputum cultures positive for P.aeruginosa?				☐ Yes	☐ No
Is FEV_1 between 25-80 predicted?	☐ Yes	☐ No	Is member colonized with Burkholderia cepacian?	☐ Yes	☐ No

☐ **Bethkis**				☐ **Kitabis**				
Is FEV_1 between 40-80% predicted?	☐ Yes	☐ No		Is FEV_1 between 25-75% predicted?	☐ Yes	☐ No		
Are sputum cultures positive for *P.aeruginosa?*	☐ Yes	☐ No		Is member colonized with *Burkholderia cepacian?*	☐ Yes	☐ No		
☐ **Tobi Podhaler OR Tobramycin Nebulizer Solution - Generic for Tobi**								
Is FEV1 between 25-80%?	☐ Yes	☐ No		Is FEV1 between 25-75% predicted?	☐ Yes	☐ No		
Did member have inadequate response OR intolerable side effect with Bethkis AND Kitabis?					☐ Yes	☐ No		
☐ **Non-Cystic Fibrosis Bronchiectasis:**	☐ **Tobramycin Nebulizer Solution (generic for Tobi)**		☐ **Kitabis**	☐ **Bethkis**	☐ **Tobi Podhaler**			
Did member have frequent acute exacerbations (THREE or more exacerbations OR TWO hospitalizations within ONE year) OR progressive deterioration of lung function?					☐ Yes	☐ No		
Do sputum cultures OR chart notes document presence of pseudomonas aeruginosa?					☐ Yes	☐ No		
Was there trial with formulary alternatives (ciprofloxacin, amoxicillin, amoxicillin-clavulanic, doxycycline OR clarithromycin)?	☐ Yes	☐ No		Does member have contraindication to formulary alternatives?	☐ Yes	☐ No		
Was there inadequate response OR intolerable side effect with Bethkis AND Kitabis	☐ Yes	☐ No	☐ N/A					
☐ **Cayston**								
Is FEV_1 between 25-75% predicted?	☐ Yes	☐ No		Are sputum cultures positive for P.aeruginosa?	☐ Yes	☐ No		
Is member colonized with Burkholderia cepacian?	☐ Yes	☐ No		Is member pregnant?	☐ Yes	☐ No		
Was there inadequate response OR contraindication OR intolerance with TWO different formulary tobramycin nebulizer solution products?	☐ Yes	☐ No		Did sputum cultures show resistance to tobramycin?	☐ Yes	☐ No		
☐ **Kalydeco**								
Is there ONE gating mutation OR ONE residual function mutation in CFTR gene that is responsive to Kalydeco?	☐ Yes	☐ No		Is member homozygous for F508del mutation in CFTR gene?	☐ Yes	☐ No		
For pediatric members ONLY: Was eye examination completed at baseline AND will continue periodically throughout therapy?	☐ Yes	☐ No	☐ N/A					
Are ALTs and ASTs being monitored AND LFTs being evaluated?	☐ Yes	☐ No		For members with moderated to severe hepatic impairment ONLY: Was dose reduced?	☐ Yes	☐ No	☐ N/A	
For members taking moderate OR strong CYP3A inhibitor (fluconazole, erythromycin, ketoconazole, itraconazole, posaconazole, voriconazole, telithromycin OR clarithromycin) was Kalydeco dose REDUCED?					☐ Yes	☐ No	☐ N/A	
☐ **Orkambi**								
Is member homozygous for F508del mutation in CFTR gene?					☐ Yes	☐ No		
For pediatric members ONLY: Was eye examination completed at baseline AND will continue periodically throughout therapy?	☐ Yes	☐ No	☐ N/A					
Are ALTs and ASTs being monitored AND LFTs being evaluated?	☐ Yes	☐ No		For members with moderated to severe hepatic impairment ONLY: Has dose been reduced?	☐ Yes	☐ No	☐ N/A	
If member is currently taking MODERATE OR STRONG CYP3A inhibitor (fluconazole, erythromycin, ketoconazole, itraconazole, posaconazole, voriconazole, telithromycin OR clarithromycin) was Orkambi dose REDUCED?					☐ Yes	☐ No	☐ N/A	
☐ **Symdeko**								
Lab results are present to support ONE of the following:	☐ Member IS HOMOzygous for F508del mutation in CFTR gene		☐ There is at least ONE mutation in CFTR gene that is responsive to Symdeko					
For members that are HOMOzygous for F508del mutation in CFTR gene, was there inadequate response OR intolerable side effect with Orkambi?					☐ Yes	☐ No	☐ N/A	
For pediatric members ONLY: Was eye examination completed at baseline AND will continue periodically throughout therapy?					☐ Yes	☐ No	☐ N/A	
Are ALTs / ASTs being monitored AND LFTs being evaluated?	☐ Yes	☐ No		For members with moderated to severe hepatic impairment ONLY: Has dose been reduced?	☐ Yes	☐ No	☐ N/A	
For members taking moderate OR strong CYP3A inhibitor (fluconazole, erythromycin, ketoconazole, itraconazole, posaconazole, voriconazole, telithromycin OR clarithromycin) was Symdeko dose REDUCED?					☐ Yes	☐ No	☐ N/A	
☐ **Trikafta**								
Is there documentation of pretreatment FEV_1?	☐ Yes	☐ No		Does member have at least ONE F508del mutation in CFTR gene?	☐ Yes	☐ No		
Is member HOMOZYGOUS for F508del mutation in CFTR gene?	☐ Yes	☐ No		Was their inadequate response, or intolerable side effect with Orkambi?	☐ Yes	☐ No	☐ N/A	
For members with moderated to severe hepatic impairment ONLY: Has dose been reduced?					☐ Yes	☐ No	☐ N/A	
For members taking moderate OR strong CYP3A inhibitor (fluconazole, erythromycin, ketoconazole, itraconazole, posaconazole, voriconazole, telithromycin OR clarithromycin) was Trikafta dose					☐ Yes	☐ No	☐ N/A	

REDUCED?			

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 833-711-0776 to check the status of a request.