



Fax completed prior authorization request form to 855-247-3677 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/rbha-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:		Height:	
				<input type="checkbox"/> Male <input type="checkbox"/> Female			
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:		<input type="checkbox"/> Bethkis		<input type="checkbox"/> Kitabis			
Non-preferred Agents:		<input type="checkbox"/> Cayston		<input type="checkbox"/> Kalydeco		<input type="checkbox"/> Pulmozyme	
		<input type="checkbox"/> Symdeko		<input type="checkbox"/> Tobramycin Nebulizer Sol		<input type="checkbox"/> Orkambi	
				<input type="checkbox"/> Tobi Podhaler		<input type="checkbox"/> Trikafta	
Are there any contraindications to formulary medications? (if yes, specify):				<input type="checkbox"/> Yes		<input type="checkbox"/> No	
				<input type="checkbox"/> New request		<input type="checkbox"/> Continuation of therapy	
<input type="checkbox"/> Continuation of Therapy for <u>Non-Cystic Fibrosis Bronchiectasis</u> (Tobramycin nebulizer solution OR Kitabis OR Tobi Podhaler OR Bethkis ONLY):				<input type="checkbox"/> Response to therapy			
<input type="checkbox"/> Continuation of Therapy for Kalydeco OR Symdeko OR Orkambi OR Trikafta ONLY):				<input type="checkbox"/> Response with improvement and/or stable FEV ₁		<input type="checkbox"/> Pediatric members ONLY: Eye exam	
				<input type="checkbox"/> ALT/AST monitoring		<input type="checkbox"/> D/C if ALT/AST >5 times ULN	
				<input type="checkbox"/> 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							
<input type="checkbox"/> Standard – (24 hours)		<input type="checkbox"/> 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							
<input type="checkbox"/> Pulmozyme							
Does member have diagnosis of Cystic Fibrosis?		<input type="checkbox"/> Yes		<input type="checkbox"/> No		Is member at least 5 years of age?	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Tobramycin Nebulizer Solution - Generic for Tobi							
Are sputum cultures positive for P.aeruginosa?						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is FEV ₁ between 25-80 predicted?		<input type="checkbox"/> Yes		<input type="checkbox"/> No		Is member colonized with Burkholderia cepacian?	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	

<input type="checkbox"/> Bethkis			<input type="checkbox"/> Kitabis		
Is FEV ₁ between 40-80% predicted?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is FEV ₁ between 25-75% predicted?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are sputum cultures positive for <i>P.aeruginosa</i> ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is member colonized with <i>Burkholderia cepacia</i> ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Tobi Podhaler OR Tobramycin Nebulizer Solution - Generic for Tobi					
Is FEV ₁ between 25-80%?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is FEV ₁ between 25-75% predicted?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did member have inadequate response OR intolerable side effect with Bethkis AND Kitabis?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Non-Cystic Fibrosis Bronchiectasis:		<input type="checkbox"/> Tobramycin Nebulizer Solution (generic for Tobi)		<input type="checkbox"/> Kitabis	<input type="checkbox"/> Bethkis
Did member have frequent acute exacerbations (THREE or more exacerbations OR TWO hospitalizations within ONE year) OR progressive deterioration of lung function?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do sputum cultures OR chart notes document presence of pseudomonas aeruginosa?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was there trial with formulary alternatives (ciprofloxacin, amoxicillin, amoxicillin-clavulanic, doxycycline OR clarithromycin)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member have contraindication to formulary alternatives?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was there inadequate response OR intolerable side effect with Bethkis AND Kitabis			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<input type="checkbox"/> Cayston					
Is FEV ₁ between 25-75% predicted?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are sputum cultures positive for <i>P.aeruginosa</i> ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is member colonized with <i>Burkholderia cepacia</i> ?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is member pregnant?	
Was there inadequate response OR contraindication OR intolerance with TWO different formulary tobramycin nebulizer solution products?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Did sputum cultures show resistance to tobramycin?	
<input type="checkbox"/> Kalydeco					
Is there ONE gating mutation OR ONE residual function mutation in CFTR gene that is responsive to Kalydeco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is member homozygous for F508del mutation in CFTR gene?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
For pediatric members ONLY: Was eye examination completed at baseline AND will continue periodically throughout therapy?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Are ALTs and ASTs being monitored AND LFTs being evaluated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	For members with moderate to severe hepatic impairment ONLY: Was dose reduced?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
For members taking moderate OR strong CYP3A inhibitor (fluconazole, erythromycin, ketoconazole, itraconazole, posaconazole, voriconazole, telithromycin OR clarithromycin) was Kalydeco dose REDUCED?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Orkambi					
Is member homozygous for F508del mutation in CFTR gene?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
For pediatric members ONLY: Was eye examination completed at baseline AND will continue periodically throughout therapy?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Are ALTs and ASTs being monitored AND LFTs being evaluated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	For members with moderate to severe hepatic impairment ONLY: Has dose been reduced?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If member is currently taking MODERATE OR STRONG CYP3A inhibitor (fluconazole, erythromycin, ketoconazole, itraconazole, posaconazole, voriconazole, telithromycin OR clarithromycin) was Orkambi dose REDUCED?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Symdeko					
Lab results are present to support ONE of the following:	<input type="checkbox"/> Member IS HOMOzygous for F508del mutation in CFTR gene		<input type="checkbox"/> 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?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
For pediatric members ONLY: Was eye examination completed at baseline AND will continue periodically throughout therapy?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are ALTs / ASTs being monitored AND LFTs being evaluated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	For members with moderate to severe hepatic impairment ONLY: Has dose been reduced?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
For members taking moderate OR strong CYP3A inhibitor (fluconazole, erythromycin, ketoconazole, itraconazole, posaconazole, voriconazole, telithromycin OR clarithromycin) was Symdeko dose REDUCED?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Trikafta					
Is there documentation of pretreatment FEV ₁ ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member have at least ONE F508del mutation in CFTR gene?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is member HOMOZYGOUS for F508del mutation in CFTR gene?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was their inadequate response, or intolerable side effect with Orkambi?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
For members with moderate to severe hepatic impairment ONLY: Has dose been reduced?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
For members taking moderate OR strong CYP3A inhibitor (fluconazole, erythromycin, ketoconazole, itraconazole, posaconazole, voriconazole, telithromycin OR clarithromycin) was Trikafta dose				<input type="checkbox"/> Yes	<input type="checkbox"/> No

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 800-564-5465 to check the status of a request.