pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

# CFTR MODULATORS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for CFTR Modulators and Quantity Limits/Daily Dose Limits are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

| | | | |
|---|---|---|---|
| ☐New request ☐Renewal request | # of pages: _____ | Prescriber name: | |
| Name of office contact: | | Specialty: | |
| Contact's phone number: | | NPI: | State license #: |
| LTC facility contact/phone: | | Street address: | |
| Beneficiary name: | | City/State/Zip: | |
| Beneficiary ID#: | DOB: | Phone: | Fax: |

## CLINICAL INFORMATION

| | | |
|---|---|---|
| Drug requested: | Strength: | Formulation (granules, kit, tablet, etc.): |
| Dose/directions: | Quantity: | Refills: |
| Diagnosis *(submit documentation)*: | Dx code (*required*): | |
| Is the medication being prescribed by or in consultation with a pulmonologist or CF specialist? | ☐Yes ☐No | *Submit documentation of consultation, if applicable.* |
| Does the beneficiary have liver disease or liver impairment? | ☐Yes ☐No | *Submit documentation.* |
| Is the beneficiary taking a moderate or strong cytochrome P450 3A inhibitor? *Check all that apply.*<br>☐azole antifungal (e.g., fluconazole, ketoconazole, itraconazole, posaconazole, voriconazole)<br>☐macrolide antibiotic (e.g., clarithromycin, erythromycin, telithromycin) | ☐Yes ☐No | *Submit beneficiary's complete current medication list.* |
| Is the beneficiary taking a strong cytochrome P450 3A inducer? *Check all that apply.*<br>☐carbamazepine ☐phenytoin ☐rifampin<br>☐phenobarbital ☐rifabutin ☐St. John's wort | ☐Yes ☐No | *Submit beneficiary's complete current medication list.* |

**INITIAL requests**

Check all of the following that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐Has a CFTR genotype that is responsive to the requested CFTR Modulator as described in the package labeling
☐Has results of baseline (pre-treatment) liver function tests (ALT, AST, bilirubin)

**RENEWAL requests**

Check all of the following that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐Is experiencing clinical benefit from the requested CFTR Modulator
☐Has results of recent liver function tests (ALT, AST, bilirubin) *Note: LFTs should be evaluated every 3 months for the first year of therapy and annually thereafter.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

| | |
|---|---|
| Prescriber Signature: | Date: |