OPTUMRx®

OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Orkambi® Prior Authorization Request Form (Page 1 of 2)

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): _____

Clinical Information:

Is the patient homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene as detected by an FDA-cleared cystic fibrosis mutation test or Clinical Laboratory Improvement Amendments (CLIA)-approved facility?* ❑ **Yes** ❑ **No**

**Please note: Laboratory results of the above is required to be submitted along with this fax.*

Is Orkambi prescribed by or in consultation with a specialist affiliated with a CF care center or pulmonologist? ❑ **Yes** ❑ **No**

For requests for granules packets:

Is the patient able to swallow oral tablets? ❑ **Yes** ❑ **No**

Reauthorization:

Is the patient benefiting from treatment (i.e., improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations)? ❑ **Yes** ❑ **No**

Select if the patient has achieved a clinically meaningful response while on Orkambi as attested by the prescriber based on the following:

- ❑ Lung function as demonstrated by percent predicted forced expiratory volume in 1 second (ppFEV1)
- ❑ Body mass index (BMI)
- ❑ Pulmonary exacerbations
- ❑ Quality of life as demonstrated by Cystic Fibrosis Questionnaire-Revised (CFQ-R) respiratory domain score

Is Orkambi prescribed by or in consultation with a specialist affiliated with a CF care center or pulmonologist? ❑ **Yes** ❑ **No**

For requests for granules packets:

Is the patient able to swallow oral tablets? ❑ **Yes** ❑ **No**

Quantity Limit:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading-dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____
- ❑ Other: _____

Orkambi® Prior Authorization Request Form (Page 2 of 2)

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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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.