Aetna Better Health®

Fax completed prior authorization request form to 855-799-2554 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.aetnabetterhealth.com/florida/providers/provider-pharmacy

Kalydeco-Orkambi-Symdeko-Trikafta
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 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			
☐ Kalydeco	☐ Orkambi	☐ Symdeko	☐ Trikafta
Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): Yes No	Diagnosis:		ICD-10 Code:
Are there any contraindications to formulary medications? If yes, please specify:	☐ Yes ☐ No	☐ New request	☐ Continuation of therapy
Directions for Use:	Strength:		Dosage Form:
	Quantity:	Day Supply:	Duration of Therapy/Use:
What medication(s) has the member tried and failed for this diagnosis? Please specify below.			

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

Clinical Information				
Does member have documented diagnosis of Cystic Fibrosis confirmed via 'health conditions' OR medical records?			☐ Yes	☐ No
Have baseline liver tests been completed AND then will be completed every 3 months the 1st year THEN annually?			☐ Yes	☐ No
Was a baseline ophthalmic exam completed?	☐ Yes ☐ No ☐ N/A	Was baseline % predicted FEV1 completed within past 30 days?	☐ Yes	☐ No

☐ Kalydeco		
Did member have genetic testing confirming presence of ONE CFTR mutation?	☐ Yes	☐ No

☐ Orkambi		
Was member determined to be HOMOzygous for the F508del mutation in CFTR gene as confirmed by an FDA-approved CF mutation test?	☐ Yes	☐ No

☐ Symdeko					
Is member HOMOzygous for the F508del mutation?	☐ Yes	☐ No	Does member have at least ONE mutation in CFTR gene, that is responsive to tezacaftor-ivacaftor, based on in vitro date AND/OR clinical evidence?	☐ Yes	☐ No
CFTR mutations responsive to tezacaftor-ivacaftor:E56K, P67L, R74W, D110E, D110H, R117C, E193K, L206W, R347H, R352Q, A455E, D579G, 711+3A→G, E831X, S945L, S977F, F1052V, K1060T, A1067T, R1070W, F1074L, D1152H, D1270N, 2789+5G→A, 3272-26A→G, and 3849+10kbC→T					
Is members' genotype unknown?	☐ Yes	☐ No	Was an FDA-cleared cystic fibrosis mutation test used to detect presence of CFTR mutation?	☐ Yes	☐ No ☐ N/A

☐ Trikafta					
Is member HOMOzygous for the F508del mutation?				☐ Yes	☐ No
Is members' genotype unknown?	☐ Yes	☐ No	Was an FDA-cleared cystic fibrosis mutation test used to detect presence of CFTR mutation?	☐ Yes	☐ No

☐ **Renewal Only**						
Member experienced response by TWO or more of the following?	☐ Decreased pulmonary exacerbations compared to pretreatment baseline					
	☐ Improvement OR stabilization of lung function (as measured by % predicted FEV1) compared to baseline OR decrease in rate of decline of lung function					
	☐ Weight gain					
	☐ Improvement in patient symptoms as documented in clinical notes					
Did member receive lung transplant?	☐ Yes	☐ No	Did member experience unacceptable toxicity from requested medication?	☐ Yes	☐ No	
Was annual follow-up ophthalmic exam completed?	☐ Yes	☐ No	Were annual LFTs completed?	☐ Yes	☐ No	

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:** _________________

<u>Please note: Incomplete forms or forms without the chart notes will be returned</u>

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 to check the status of a request.
Medicaid: 800-441-5501
Florida Healthy Kids: 844-528-5815