aetna™

Aetna Better Health®

Fax completed prior authorization request form to 844-802-1412 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 https://www.aetnabetterhealth.com/Illinois-medicaid

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						
☐ Tobramycin Nebulizer	☐ Tobi Podhaler	☐ Bethkis	☐ Cayston	☐ Kalydeco	☐ Orkambi	☐ Symdeko
☐ Trikafta	☐ Other, please specify:					

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:

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

☐ **Tobramycin Nebulizer Solution (Generic for Tobi)**					
Does member have diagnosis of Cystic Fibrosis?	☐ Yes	☐ No	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

☐ **Tobi Podhaler**			☐ **Bethkis**		
Are sputum cultures positive for P.aeruginosa?	☐ Yes	☐ No	Is member colonized with Burkholderia cepacian?	☐ Yes	☐ No
Is FEV1 between 25-80% predicted?	☐ Yes	☐ No	Was there trial and failure with Tobramycin Nebulizer Solution (generic for Tobi)?	☐ Yes	☐ No

☐ **Non-Cystic Fibrosis Bronchiectasis**								
☐ **Tobramycin Nebulizer Solution (generic for Tobi)**		☐ **Tobi Podhaler**		☐ **Bethkis**				
Do sputum cultures OR chart notes document presence of pseudomonas aeruginosa?							☐ Yes	☐ No
Was there trial AND failure with formulary alternatives such as ciprofloxacin, amoxicillin, amoxicillin-clavulanic, doxycycline OR clarithromycin?	☐ Yes	☐ No	Are formulary alternatives contraindicated for diagnosis?				☐ Yes	☐ No
☐ Tobi Podhaler OR Bethkis:								
Was there inadequate response OR intolerable side effect with tobramycin nebulizer solution (generic)?							☐ Yes	☐ No
☐ **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 the member pregnant?				☐ Yes	☐ No
Is member colonized with Burkholderia cepacian?							☐ Yes	☐ No
Was there inadequate response OR contraindication / 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
Does member have moderate to severe hepatic impairment?	☐ Yes	☐ No	☐ Member is currently taking a STRONG CYP3A INHIBITOR such as ketoconazole, itraconazole, posaconazole, voriconazole, telithromycin OR clarithromycin **AND** prescriber will reduce Orkambi dose.					
If answered yes, was dose reduced?	☐ Yes	☐ No						
☐ **Renewal ONLY**								
Is there documentation to support response to therapy (symptom improvement AND/OR stable FEV1)?							☐ Yes	☐ No
Was ALT / AST monitored and LFTs evaluated?	☐ Yes	☐ No	Will provider temporarily D/C Kalydeco if ALT/AST >5x ULN?				☐ Yes	☐ No
Will provider temporarily D/C Kalydeco if ALT / AST >3 x ULN with bilirubin >2 x ULN?							☐ Yes	☐ No
☐ Pediatric members ONLY:								
Was eye examination completed at baseline AND will continue periodically throughout therapy?							☐ Yes	☐ No
☐ **Orkambi**								
Is member homozygous for F508Del at the CFTR gene?							☐ Yes	☐ No
Is genotype unknown?	☐ Yes	☐ No	Was FDA-cleared CF mutation test used to detect presence of F508del mutation on both alleles of CFTR gene?				☐ Yes	☐ No
Does member have moderate to severe hepatic impairment?	☐ Yes	☐ No	If answered yes, was dose reduced?				☐ Yes	☐ No
☐ **Renewal ONLY**								
Is there documentation to support response to therapy (symptom improvement AND/OR stable FEV1)?							☐ Yes	☐ No
Is ALT / AST monitored AND LFTs evaluated?	☐ Yes	☐ No	Will provider temporarily D/C Orkambi if ALT/AST >5x ULN?				☐ Yes	☐ No
Will provider temporarily D/C Orkambi if ALT / AST >3 x ULN with bilirubin >2 x ULN?							☐ Yes	☐ No
☐ Pediatric members ONLY:								
Was eye examination completed at baseline AND will continue periodically throughout therapy?							☐ Yes	☐ No
☐ **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 who are homozygous for F508del mutation in the CFTR gene, there was inadequate response OR intolerable side effect with Orkambi								
☐ Does member have moderate to severe hepatic impairment?	☐ Yes	☐ No	If answered yes, was dose reduced?				☐ Yes	☐ No
☐ **Renewal ONLY**								
Is there documentation to support response to therapy (symptom improvement AND/OR stable FEV1)?							☐ Yes	☐ No

Is ALT / AST monitored AND LFTs evaluated?	☐ Yes	☐ No	Will provider temporarily D/C Symdeko if ALT/AST >5x ULN?	☐ Yes	☐ No
Will provider temporarily D/C Symdeko if ALT / AST >3 x ULN with bilirubin >2 x ULN?				☐ Yes	☐ No
☐ For pediatric members ONLY:					
Was eye examination completed at baseline AND will continue periodically throughout therapy?				☐ Yes	☐ No

☐ **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	
Does member have moderate to severe hepatic impairment?	☐ Yes	☐ No	If yes was dose was reduced?	☐ Yes	☐ No		
☐ Member is currently taking a STRONG CYP3A INHIBITOR such as ketoconazole, itraconazole, posaconazole, voriconazole, telithromycin OR clarithromycin AND prescriber will reduce Trikafta dose							
☐ **Renewal ONLY**							
Is there documentation to support response to therapy (symptom improvement AND/OR stable FEV1)?						☐ Yes	☐ No
Is ALT / AST monitored AND LFTs evaluated?	☐ Yes	☐ No	Will provider temporarily D/C Trikafta if ALT/AST >5x ULN?			☐ Yes	☐ No
Will provider temporarily D/C Trikafta if ALT / AST >3 x ULN with bilirubin >2 x ULN?						☐ Yes	☐ No
☐ Pediatric members ONLY:							
Was eye examination completed at baseline AND will continue periodically throughout therapy?						☐ 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:** _____

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 866-329-4701 to check the status of a request.