

**AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM**  
**DUR MEDICATION ALYFTREK™ (vanzacaftor/tezacaftor/deutivacaftor)**

**Fax back to: 1-855-799-2553**

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If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

**MEMBER INFORMATION**

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Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Medicaid ID Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Weight in Kilograms: \_\_\_\_\_

**PRESCRIBER INFORMATION**

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Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

NPI Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

**DRUG INFORMATION**

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Drug Name/Form: \_\_\_\_\_

Strength: \_\_\_\_\_

Dosing Frequency: \_\_\_\_\_

Length of Therapy: \_\_\_\_\_

Quantity per Day: \_\_\_\_\_

*(Form continued on next page.)*

Member's Last Name:

Member's First Name:

**DIAGNOSIS AND MEDICAL INFORMATION**

**ALYFTREK™ – to receive a ONE (1) year approval for this drug, complete the following questions.**

1. Does the member have a diagnosis of cystic fibrosis (CF)?  
 Yes     No
2. Is the member 6 years of age or older?  
 Yes     No
3. Does the member have at least one F508del mutation or other responsive mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene, as confirmed by an FDA-cleared CF mutation test? (*Documentation required – include a copy of the test with this fax.*)  
 Yes     No
4. Is the member receiving concurrent treatment with another CFTR modulator?  
 Yes     No
5. Have baseline liver function tests (e.g., ALT, AST, bilirubin) been performed and will be reassessed and monitored regularly during treatment (every month for first 6 months, every 3 months for next 12 months, then at least annually)? (*Documentation required – include a copy of the test with this fax.*)  
 Yes     No
6. Does the member have severe hepatic impairment (Child-Pugh Class C)?  
 Yes     No

**For renewal, complete the following questions to receive a 1-year approval:**

7. Does the member continue to meet the above criteria (questions 1 through 6)?  
 Yes     No
8. Does the member continue to experience clinical benefit from the requested treatment?  
 Yes     No

*(Form continued on next page.)*

**Member's Last Name:**

**Member's First Name:**

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**Prescriber Signature (Required)**

**Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

**Please include ALL requested information; incomplete forms will delay the PA process.**

Submission of documentation does NOT guarantee coverage.