Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
TRIKAFTA (Elexacaftor-Tezacaftor-Ivacaftor) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **TRIKAFTA (Elexacaftor-Tezacaftor-Ivacaftor) .** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103.

Requests will not be considered unless all sections are complete.

KP-MAS Formulary can be found at: http://www.providers.kaiserpermanente.org/mas/formulary.html

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, State date: _____
2. Indicate the Member's diagnosis for the requested medication: _____
3. Is the member ≥12 years of age? **AND**
   □ No □ Yes
4. Was the member diagnosis of CF confirmed by a clinician with expertise in providing CF care? **AND**
   □ No □ Yes
5. At least one F508del mutation in the CFTR gene detected using either an FDA-cleared CF mutation test or testing was completed by a CLIA certified laboratory? **AND**
   □ No □ Yes
6. Member does not have either of the following:
   a. Severe liver impairment (Child-Pugh Class C), **OR**
   b. Prior solid organ or hematological transplantation, unless use of the medication is approved by the transplant center

   □ No □ Yes

For Continuation of Therapy, Please Respond to Additional Questions Below:

1. Was there documentation of positive clinical response? **AND**
   □ No □ Yes
2. Did the specialist follow-up occur in the past 12 months? **AND**
   AST, ALT, bilirubin and ophthalmic changes (patients up to 17 years) are monitored at least annually
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information – Please submit chart notes/medical records for the patient that are applicable to this request. Provide any additional supporting information that should be taken into consideration:

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**