Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
ORKAMBI (Lumacaftor-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 **ORKAMBI (Lumacaftor-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

Is the prescriber a Specialist in Management of Cystic Fibrosis? □ No □ Yes

If consulted with a specialist, specialist name and specialty: ____

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 ≥2 years of age? **AND**
   □ No □ Yes
4. Was the member diagnosis of CF confirmed by a clinician with expertise in proving 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. If the member is ≥6 years of age, baseline percent predicted FEV1 is ≥30%?
   □ 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:**

Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility