# Trikafta (elexacaftor/tezacaftor/ivacaftor)
# Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

**MEMBER'S LAST NAME:** _____ **MEMBER'S FIRST NAME:** _____

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

| **MEMBER INFORMATION** | |
|---|---|
| **LAST NAME:** | **FIRST NAME:** |
| **PHONE NUMBER:** | **DATE OF BIRTH:** |
| **STREET ADDRESS:** | |
| **CITY:** | **STATE:** **ZIP CODE:** |
| **PATIENT INSURANCE ID NUMBER:** | |

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

**IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP**

**PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):** _____
**AUTHORIZED REPRESENTATIVE'S PHONE NUMBER:** _____

| **PRESCRIBER INFORMATION** | |
|---|---|
| **LAST NAME:** | **FIRST NAME:** |
| **PRESCRIBER SPECIALTY:** | **EMAIL ADDRESS:** |
| **NPI NUMBER:** | **DEA NUMBER:** |
| **PHONE NUMBER:** | **FAX NUMBER:** |
| **STREET ADDRESS:** | |
| **CITY:** | **STATE:** **ZIP CODE:** |
| **REQUESTER (if different than prescriber):** | **OFFICE CONTACT PERSON:** |

| **MEDICATION OR MEDICAL DISPENSING INFORMATION** | | | |
|---|---|---|---|
| **MEDICATION NAME:** | | | |
| **DOSE/STRENGTH:** | **FREQUENCY:** | **LENGTH OF THERAPY/REFILLS:** | **QUANTITY:** |
| ☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES): | | | |

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| **1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?** ☐ **YES** (if yes, complete below) ☐ **NO** | | |
|---|---|---|
| **MEDICATION/THERAPY** (SPECIFY DRUG NAME AND DOSAGE)**:** | **DURATION OF THERAPY** (SPECIFY DATES)**:** | **RESPONSE/REASON FOR FAILURE/ALLERGY:** |
| | | |

| **2. LIST DIAGNOSES:** | **ICD-10:** |
|---|---|
| ☐ Cystic fibrosis<br>☐ Other diagnosis: _____ ICD-10 Code(s): | |

**3. REQUIRED CLINICAL INFORMATION:** PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

**Is patient going to be using drug in a clinical trial? ☐ Yes ☐ No**

**Is this request for initial therapy (meaning the patient has not received therapy with Trikafta in the past AND there are no paid claims for Trikafta in member's history)? □ Yes □ No**

***If No, please complete "Renewal Therapy" section below.***

**Is this patient HOMOZYGOUS for the F508del CFTR mutation? □ Yes □ No *Test documentation must be provided.***

**Is this patient HETEROZYGOUS for the F508del CFTR mutation? □ Yes □ No *Test documentation must be provided.***

**Is patient considered HETEROZYGOUS Class I or II □ Yes □ No?**

**Is patient considered HETEROZYGOUS Class III, IV, V or VI □ Yes □ No?**

**Please provide patient's mutation:_____ Please also submit Test documentation.**

**If patient is HETEROZYGOUS for the F508del, please also answer the following:**
**Is the patient's OTHER (non-F508del) mutation currently listed within the FDA package insert for Trikafta?**
**□ Yes □ No *Test documentation must be provided.***

**FOR INITIAL REQUESTS ONLY:**
**If patient is under the age of 6 years, please answer the following:**
**Does patient have documentation of compromised lung function with at least one of the following: □ Yes □ No**
***Documentation must be provided.***
**□ Infant Pulmonary Function Test(IPFT)**
**□ Number of or history of cystic fibrosis(CF) exacerbations requiring antibiotics either outpatient or inpatient**
**□ CT evidence of persistent bronchiectasis**

**If patient is 6 years of age or older, please answer the following:**

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**Is patient's FEV1 40-100% inclusive, obtained while the patient is NOT receiving treatment with Trikafta or any other CFTR medication (Kalydeko,Orkambi or Symdeko)? □ Yes □ No**
***Please submit this documentation from patient's chart.***

**FOR RENEWAL REQUESTS ONLY:**
**You must answer ALL of the following questions.**

**Is this request for renewal of therapy (meaning the patient is currently receiving therapy AND paid claims are in member's history)? □ Yes □ No**
***Note: use of samples only and/or access through patient assistance program only does not qualify as current therapy subject to renewal; those should be submitted as initial therapy instead.***

***If No, please complete "Initial Therapy" section above.***

**Has patient had a lung transplant? □ Yes □ No**

**Is patient considered HETEROZYGOUS CFTR mutation Class I or II □ Yes □ No?**

**Is patient considered HETEROZYGOUS CFTR mutation Class III, IV, V or VI □ Yes □ No?**

**Is patient considered HOMOZYGOUS? □ Yes □ No?**

**For patients under 6 years of age, please answer the following:**
**Does patient have a disease response as indicated by one or more of the following: □ Yes □ No *Please submit this documentation, e.g., chart notes***
**□ Decreased pulmonary exacerbations compared to pre-treatment baseline**
**□ Decrease in decline of lung function as measured by percent predicated FEV1 from date of start of Trikafta(elexacaftor/tezacaftor/ivacaftor)**
**□ Improvement in quality of life demonstrated by at least 2 of the following:**
- **□ Cystic Fibrosis Questionnaire-Revised Score(CFQ-R)**
- **□ Weight gain**
- **□ Increase in height.**

**For patients 6 years of age or older, please answer the following**

***Current FEV1 percentage of predicted measurement is defined as the most recent FEV1 percentage of predicted that was measured* between 4-12 weeks AFTER initiating and while the patient is receiving treatment with *Trikafta. Please submit this documentation, such as chart notes.***

**If patient is considered HETEROZYGOUS CFTR mutation Class I or II, has patient demonstrated an increase of at least 12 absolute percentage points in their FEV1 percentage of predicted measurement? □ Yes □ No Please provide documentation.**

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**If patient is considered HETEROZYGOUS CFTR mutation Class III, IV, V or VI, has patient demonstrated an increase of at least 3 absolute percentage points in their FEV1 percentage of predicted measurement? □ Yes □ No Please provide documentation.**
**If patient is considered HOMOZYGOUS, has patient demonstrated an increase of at least 8 absolute percentage points in their FEV1 percentage of predicted measurement? □ Yes □ No Please provide documentation.**
**If patient had an initial $FEV_1$ predicted of 90% to 100% at baseline prior to starting Trikafta, is patient stable at 90% or greater after being on treatment with Trikafta? □ Yes □ No Please provide documentation.**

**Has patient's $FEV_1$ predicted decreased from baseline prior to starting treatment with Trikafta? □ Yes □ No Please provide documentation.**

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

**Please note:** Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

**ATTESTATION:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature or Electronic I.D. Verification:** _____ **Date:** _____



**FAX THIS FORM TO:** 800-424-7640
**MAIL REQUESTS TO:** Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
**Phone**: 877-228-7909