

Alyftrek (Vanzacaftor; tezacaftor; deutivacaftor)

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:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page

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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:
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2. LIST DIAGNOSES:

Cystic fibrosis
 Other diagnosis: _____ ICD-10 Code(s): _____

ICD-10:

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

Will the patient be using the drug as a part of the clinical trial? Yes No

Is this request for initial therapy (meaning the patient has not received therapy with Alyftrek in the past AND there are no paid claims for Alyftrek 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 indicate what mutation the patient has: _____ Please submit Test Documentation.

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

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CT evidence of persistent bronchiectasis

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

Is patient's FEV1 40-90% inclusive, obtained while the patient is NOT receiving treatment with Alyftrek 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 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 Alyftrek. 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.

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.

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If patient had an initial FEV₁ predicted of 90% at baseline prior to starting Alyftrek, is patient stable at 90% after being on treatment with Alyftrek? Yes No

Please provide documentation.

Has patient's FEV₁ predicted decreased from baseline prior to starting treatment with Alyftrek?

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:** _____

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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