NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

WellCare
Beyond Healthcare. A Better You.

NC DHB Pharmacy Request for Prior Approval - Cystic Fibrosis Medications

Recipient Information

1. Recipient Last Name:_____2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Prescriber Information

7. Prescribing Provider #:_____ NPI: ☐ *or* Atypical: ☐
8. Prescriber DEA #: _____

Requester Contact Information:
Name:_____ Phone #:_____ Ext:_____

Drug Information

9. Drug Name: ☐ **Kalydeco** ☐ **Orkambi** 10. Strength: _____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐Other:_____

Clinical Information

For coverage of Kalydeco

1. Does the beneficiary have a diagnosis of Cystic Fibrosis? ☐ Yes ☐ No

2. Is the beneficiary age 2 or greater? ☐ Yes ☐ No

3. Does the beneficiary have a documented G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, S549R, R117H, E56K, K1060T, P67L, E193K, A1067T, R74W, L206W, G1069R, D110E, R347H, D579G, R1070Q, D1270N, D110H, R352Q, S945L, R1070W, R117C, A455E, S977F, F1074L, F1052V,or D1152H mutation in the CFTR gene?

☐ Yes ☐ No (Documentation must accompany this prior approval request)

4. Is the total daily dose prescribed 300mg/day total or less? ☐ Yes ☐ No

5. Did the beneficiary have a baseline ALT and AST assessed prior to beginning therapy? ☐ Yes ☐ No
Please list ALT and AST results and date labs were done.

5a. ALT level: _____(U/L) 5b. Date: _____ 5c. AST level: _____(U/L) 5d. Date: _____

For coverage of Orkambi

6. Does the beneficiary have a diagnosis of Cystic Fibrosis? ☐ Yes ☐ No

7. Is the beneficiary age 6 or greater? ☐ Yes ☐ No

8. Is the beneficiary documented as homozygous for the F508del mutation in the CFTR gene? ☐ Yes ☐ No

9. Will the beneficiary receive a dose of two tablets (each containing lumacaftor 200mg / ivacaftor 125mg) or less taken orally every 12 hours with fat containing food? ☐ Yes ☐ No

10. Did the beneficiary have a baseline ALT and AST assessed prior to beginning therapy? ☐ Yes ☐ No
Please list ALT and AST results and date labs were done.
10a. ALT level: _____(U/L) 10b. Date: _____ 10c. AST level: _____(U/L) 10d. Date: _____

Signature of Prescriber:_____ Date:_____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: **(800) 678-3189** Pharmacy PA Call Center: **(866) 799-5318**