TRICARE Prior Authorization Request Form for
vanzacaftor/tezacaf/deutivacaf (Alyftrek)

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100
Hanover, MD 21076

Fax completed form and applicable progress notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the patient 6 years of age or older?	☐ Yes Proceed to Question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication being prescribed by or in consultation with a pulmonologist?	☐ Yes Proceed to Question **3**	☐ No **STOP** **Coverage not approved**
3. What is the indication or diagnosis?	☐ Cystic fibrosis (CF) - Proceed to question **4** ☐ Other diagnosis **– STOP - Coverage not approved**	
4. Is the patient's genotype known?	☐ Yes Proceed to Question **5**	☐ No Proceed to Question **6**
5. Does the patient have at least one F508del mutation OR another responsive mutation to Alyftrek in the Cystic Fibrosis Transmembrane Conductance Regulator (CFTR) gene?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
6. Has an FDA-cleared cystic fibrosis (CF) mutation test been used to confirm the presence of at least one indicated mutation?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: