TRICARE Prior Authorization Request Form for
elexacaftor - tezacaftor - ivacaftor **(Trikafta)**

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.

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 requested medication being prescribed by or in consultation with a pulmonologist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is Trikafta being prescribed for the treatment of cystic fibrosis (CF)?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is this drug being requested for an FDA approved age?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient have at least one F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene as detected by an FDA-approved CF mutation test?	☐ Yes Proceed to question **6**	☐ No Proceed to question **5**
5. Does the patient have a mutation in the CFTR gene that is responsive based on in vitro data?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is the genotype known or unknown?	☐ Known - Proceed to question **8** ☐ Unknown - Proceed to question **7**	

7. Has an FDA-approved test been used to detect the presence of at least one F508del mutation or a mutation that is responsive based on in vitro data?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Is this agent being used in combination therapy with Symdeko, Orkambi or Kalydeco?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

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

_____ _____

Prescriber Signature Date

[09 June 2021]

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