

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



JOHNS HOPKINS
 MEDICINE

JOHNS HOPKINS
 HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

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

**FAX Completed Form and
 Applicable Progress Notes to:
 (410) 424-4037**

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?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Is Trikafta being prescribed for the treatment of cystic fibrosis?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Is this drug being requested for an FDA approved age?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Is this agent being used in combination therapy with Symdeko, Orkambi or Kalydeco?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> 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

[11 February 2020]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: