Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health
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Montana Medicaid Prior Authorization Request Form for Use of Orkambi® (lumacaftor/ivacaftor)

Member name:	Date:
Member ID:	DOB:
Prescriber name:	Specialty:
Prescriber phone:	Prescriber fax:

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ INITIATION OF THERAPY

1. Member is 1 year of age or older: ☐ Yes ☐ No

2. Laboratory results **are attached** confirming that member is homozygous for the F508del mutation in the cystic fibrosis transmembrane regulator (CFTR) gene: ☐ Yes ☐ No

3. Prescriber is a pulmonologist specializing in the treatment of cystic fibrosis: ☐ Yes ☐ No

4. Provider attests other current standard of care cystic fibrosis therapies have been optimized: ☐ Yes ☐ No

5. Provide baseline percent predicted expiratory volume ($ppFEV_1$): _____ Date: _____

6. History of pulmonary exacerbations within the past 12 months is provided:

_____

_____

_____

Initial authorization will be issued for 6 months.

☐ CONTINUATION OF THERAPY

1. Date medication started: _____

2. Provider attests that member has been compliant on Orkambi and other cystic fibrosis maintenance medications: ☐ Yes ☐ No (*Note: Verification of compliance will be made via Medicaid paid claims data. If non-compliance is determined, the reauthorization time frame may be reduced to allow time for the provider to address member compliance.*)

3. Provider attests that in comparison to baseline, the member has achieved a clinically meaningful response while on Orkambi therapy to one or more of the following:
    a. Lung function improvement as demonstrated by improvement or stability in $ppFEV_1$. ☐ Yes ☐ No
        i. Provide current $ppFEV_1$: _____ Date: _____
    b. Decline in pulmonary exacerbations: ☐ Yes ☐ No
    c. Stability or increase in body mass index (BMI): ☐ Yes ☐ No

4. Prescriber is a pulmonologist specializing in the treatment of cystic fibrosis: ☐ Yes ☐ No

Reauthorization will be issued for 6 months.

Please complete form, including required attachments and fax to
Drug Prior Authorization Unit at 1-800-294-1350

11/2022