Montana Healthcare Programs Prior Authorization Request Form for Use of Trikafta® (tezacaftor/ivacaftor/elexacaftor)

<table>
<thead>
<tr>
<th>Member name:</th>
<th>DOB:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member ID:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescriber name and specialty if applicable:</td>
<td>Prescriber phone:</td>
<td></td>
</tr>
<tr>
<td>Dosage requested:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

☐ INITIATION OF THERAPY

Please check appropriate diagnosis and complete corresponding information:

- Member is 6 years of age or older: ☐ Yes ☐ No

- Laboratory results are attached, confirming that the member is homozygous for the F508del mutation in the cystic fibrosis transmembrane regulator (CFTR) gene or has a mutation that is responsive based on in vitro data:
  ☐ Yes ☐ No

**Action Required:** Please indicate the gene mutation Trikafta® is being requested for: ______________________

**Gene Mutation:** _______________________________________________________________________________

- Medication is prescribed by a pulmonologist specializing in the treatment of cystic fibrosis: ☐ Yes ☐ No

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

- Provide baseline percent predicted expiratory volume (ppFEV₁): ____________ Date: _________________

- History of pulmonary exacerbations within the past 12 months is provided:
  ___________________________________________________________________________________________
  ___________________________________________________________________________________________
  ___________________________________________________________________________________________

**Initial authorization will be issued for 6 months.**
CONTINUATION OF THERAPY

- Date medication started: ________________________

- Member has been adherent to Trikafta® 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.)

- Provider attests that in comparison to baseline, the member has achieved a clinically meaningful response while on Trikafta® therapy to one or more of the following:
  - Lung function improvement as demonstrated by improvement or stability in ppFEV1: □ Yes □ No
    Provide current ppFEV1: _____________ Date: ________________
  - Decline in pulmonary exacerbations: □ Yes □ No
  - Stability or increase in body mass index (BMI): □ Yes □ No

- 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