Mountain Pacific
INNOVATING BETTER HEALTH

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

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty if applicable:	Prescriber Fax:	
Dosage Requested:		

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

☐ INITIATION OF THERAPY

Please check appropriate diagnosis and complete corresponding information:

1. Member is 2 years of age or older: ☐ Yes ☐ No
2. Laboratory results are attached to confirm 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: _____
3. Medication is prescribed by a pulmonologist specializing in the treatment of cystic fibrosis: ☐ Yes ☐ No
4. Provider attests the other current standard of care cystic fibrosis therapies have been optimized: ☐ Yes ☐ No
5. Provide baseline percent predicted expiratory volume (ppFEV1): _____ 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. 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 timeframe 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 Trikafta® therapy to one or more of the following:
    - Lung function improvement as demonstrated by improvement or stability in $ppFEV_1$: ☐ Yes ☐ No

      Provide current $ppFEV_1$: _____ Date:_____
    - Decline in pulmonary exacerbations: ☐ Yes ☐ No
    - 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