

CFTR PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today's Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis: <input type="checkbox"/> Cystic fibrosis (CF) <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

- For all requests:**
- Is the patient currently treated with the requested agent? Yes No
 - Is the patient's age within FDA labeling for the requested indication for the requested agent? Yes No
If no, please give rationale in support of using the requested agent for the patient's age for the requested indication: _____
 - Will the patient be using the requested agent in combination with another CFTR modulator agent for the requested indication? Yes No
 - Is the prescriber a specialist in the area of the patient's diagnosis (e.g., cystic fibrosis, pulmonologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? Yes No
 - Does the patient have any FDA labeled contraindications to the requested agent? Yes No
If yes, please specify FDA labeled contraindications: _____
 - Does the requested quantity (dose) exceed the maximum FDA labeled dose for the requested indication? Yes No
If yes, please give an explanation in support of therapy with a higher dose for the requested indication: _____
If no, can the requested quantity (dose) be achieved with a lower quantity of a higher strength that does NOT exceed the program quantity limit? Yes No
If no, please explain: _____
 - Does the patient have a CFTR gene mutation(s), confirmed by genetic testing, according to the FDA label for the requested agent? **Please note, medical records are required.** Yes No
 - For Kalydeco requests, does the patient have F508del mutation on BOTH alleles of CFTR gene (homozygous)? Yes No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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For renewal requests:

9. Has the patient had clinical benefit with the requested agent? Yes No

For cystic fibrosis renewal requests:

10. Has the patient had improvement or stabilization with the requested agent? [e.g., improvement or stabilization in any of the following: FEV1, weight/BMI, Cystic Fibrosis Questionnaire-Revised (CFQ-R) Respiratory Domain score, respiratory symptoms related to patients with CF (cough, sputum production, difficulty breathing number of pulmonary exacerbations)]? Yes No

Please fax or mail this form to:
 Prime Therapeutics LLC
 Clinical Review Department
 2900 Ames Crossing Road Suite 200
 Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**
BCBSIL: 800.285.9426
BCBSMT: 888.723.7443
BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

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