maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Orkambi

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Is the patient greater than or equal to 1 year of age? [If no, no further questions.]	Yes	No
2	Will the requested medication be given in combination with Kalydeco, Symdeko, or Trikafta? [If yes, no further questions.]	Yes	No
3	What is the indication or diagnosis? [] Cystic fibrosis (If checked, go to 4) [] Other (If checked, no further questions)		

If you have any questions, call: 1-888-258-8250

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4	Does the patient have cystic fibrosis that is homozygous for the F508del (Phe508del) mutation in the Cystic Fibrosis Transmembrane Regulator (CFTR) gene? [Note: This means the patient has two copies of the F508del (Phe508del) mutation.] [If no, no further questions.]	Yes	No
5	Is Orkambi being prescribed by or in consultation with a pulmonologist or a physician who specializes in the treatment of cystic fibrosis?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B: Physician Signature

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PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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