BlueCross BlueShield Federal Employee Program

ORKAMBI
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: R			Physician Signature:		
PHYSICIAN COMPLETES					

Orkambi

(lumacaftor / ivacaftor)

NOTE: Form must be completed in its **entirety** for processing

Please select dosage form: ❑**Packet** ❑**Tablet**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

How many packets/tablets will the patient need for an 84 day supply? _____ packet(s)/tablet(s) per 84 days

1. What is the patient's diagnosis?
   - ❑ Cystic Fibrosis (CF)
   - ❑ Other diagnosis ***(please specify):*** _____

2. Will Orkambi be used in combination with another *cystic fibrosis transmembrane conductance regulator (CFTR) potentiator? ❑Yes* ❑No
   ****If YES***, please specify the medication: _____
   ****CFTR Potentiators: Kalydeco (ivacaftor), Symdeko (ivacaftor/tezacaftor), Trikafta (ivacaftor/tezacaftor/elexacaftor)***

3. Has the patient been on Orkambi continuously for the last **4 months**, excluding samples? ***Please select answer below:***

   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
   - a. Is the patient homozygous for *F508del* mutation in the CFTR gene? ❑Yes* ❑No
     ****If YES***, has the mutation been confirmed by an FDA approved CF mutation test? ❑Yes ❑No
   - b. **Age 6 or Older**: Please answer the following questions:
     - i. What is the pretreatment percent predicted forced expiratory volume (ppFEV1)? _____
     - ii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to Symdeko (tezacaftor/ivacaftor)? ❑Yes ❑No
   - c. Does the patient have baseline levels of ALT, AST, and bilirubin levels greater than 3 times the upper limit of normal (ULN)? ❑Yes ❑No
   - d. What is the prescribing physician's specialty? ❑Gastroenterologist ❑Pulmonologist ❑Other specialty ***(please specify)***: _____

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
   - a. **Age 1 to 5**: Has the patient's condition improved or stabilized from baseline with therapy? ❑Yes ❑No
   - b. **Age 6 or Older**: Has the patient been stable or has there been improvement of $ppFEV_1$ from baseline? ❑Yes ❑No
   - c. Does the physician agree to test ALT, AST, and bilirubin levels annually after the first year of therapy? ❑Yes ❑No

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Orkambi – FEP MD Fax Form Revised 1/20/2023

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Orkambi – FEP MD Fax Form Revised 1/20/2023