



Commonwealth of Massachusetts  
**MassHealth Drug Utilization Review Program**  
 P.O. Box 2586, Worcester, MA 01613-2586  
**Fax:** (877) 208-7428      **Phone:** (800) 745-7318

## Cystic Fibrosis Agents Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at [www.mass.gov/druglist](http://www.mass.gov/druglist).

### Member information

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_  
 MassHealth member ID # \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Gender (Check one.)  F  M      Member's place of residence  home  nursing facility

### Medication information

**Medication requested** (Where applicable, the brand name is provided in brackets for reference.)

- |   |   |
|---|---|
| <input type="checkbox"/> Kalydeco (ivacaftor)           | <input type="checkbox"/> Tobi Podhaler (tobramycin inhalation powder) |
| <input type="checkbox"/> Orkambi (lumacaftor/ivacaftor) | <input type="checkbox"/> tobramycin inhalation solution [Bethkis]     |
| <input type="checkbox"/> Symdeko (tezacaftor/ivacaftor) | <input type="checkbox"/> Trikafta (elexacaftor/tezacaftor/ivacaftor)  |

**Dose, frequency, and duration of medication requested** \_\_\_\_\_

**Is the member stabilized on the requested medication?**  Yes. Please provide start date. \_\_\_\_\_  No

**Indication** (Check all that apply.)

Cystic Fibrosis [Please specify genetic mutation(s) below.] \_\_\_\_\_

Does the member have *Pseudomonas aeruginosa*?  Yes  No

Other \_\_\_\_\_

Is this member a referral candidate for care coordination?  Yes  No

If yes, MassHealth will offer care coordination services to this member. Please describe which additional behavioral health services would be beneficial.

### Section I. Please complete for initial requests for Kalydeco, Orkambi, Symdeko, and Trikafta.

1. Please document member's baseline body mass index (BMI). \_\_\_\_\_ Date \_\_\_\_\_
2. Please document member's baseline percent predicted forced expiratory volume in one second (ppFEV1). \_\_\_\_\_ Date \_\_\_\_\_

### Section II. Please complete for recertification requests for Kalydeco, Orkambi, Symdeko, and Trikafta.

1. Please document member's current BMI. \_\_\_\_\_ Date \_\_\_\_\_  
 Has the member demonstrated an improvement in BMI?  Yes  No
2. Please document member's current ppFEV1. \_\_\_\_\_ Date \_\_\_\_\_  
 Has the member demonstrated an improvement in lung function?  Yes  No

3. Has the member demonstrated a reduced frequency of clinical exacerbations since initiating the requested medication?  Yes  No  
 If yes, please describe. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
4. If member has not demonstrated improvement in the ppFEV1, BMI or frequency of clinical exacerbations, please document response to therapy.  
 \_\_\_\_\_  
 \_\_\_\_\_

**Section III. Please complete for Tobi Podhaler and tobramycin inhalation solution (generic Bethkis) requests.**

1. Has the member had a trial with tobramycin inhalation solution?  
 Yes. Please list the dose and frequency, dates/duration of trials, and outcomes below.  
 Dose and frequency \_\_\_\_\_ Dates/duration of use \_\_\_\_\_  
 Did the member experience any of the following?  Adverse reaction  Inadequate response  Other  
 Briefly describe details of adverse reaction, inadequate response, or other.  
 \_\_\_\_\_  
 No. Please explain. \_\_\_\_\_
2. For Tobi Podhaler, is there medical necessity for the use of the Podhaler formulation?  Yes. Please describe. \_\_\_\_\_  No

**Section IV. Please include any other pertinent information (if needed).**

\_\_\_\_\_  
 \_\_\_\_\_

**Section V. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.**

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

\_\_\_\_\_  
 \_\_\_\_\_

**Prescriber information**

Last name\* \_\_\_\_\_ First name\* \_\_\_\_\_ MI \_\_\_\_\_  
 NPI\* \_\_\_\_\_ Individual MH Provider ID \_\_\_\_\_  
 DEA No. \_\_\_\_\_ Office Contact Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 E-mail address \_\_\_\_\_  
 Telephone No.\* \_\_\_\_\_ Fax No.\* \_\_\_\_\_

\* Required

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**Prescribing provider's attestation, signature, and date**

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

**Signature required** \_\_\_\_\_

Printed name of prescribing provider \_\_\_\_\_ Date \_\_\_\_\_