STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110 or (860) 269-2035

CYSTIC FIBROSIS Prior Authorization (PA) Request Form
CT Medical Assistance Program
[To be used for the authorization of Kalydeco, Orkambi, Symdeko, and Trikafta]

To Be Completed By Prescriber

Prescriber Information	Patient Information
Prescriber's NPI:	Patient's Medicaid ID Number:
Prescriber's Name:	Patient's Name:
Prescriber's Phone # ( )	Patient's Date of Birth (MM/DD/CCYY):
Prescriber's Fax # ( )	
Prescription Information	
Drug Requested:	
Quantity Requested:	Frequency of Dosing:
Pharmacy's Fax: ( )	

Clinical Information

Kalydeco: Is the patient 1 month of age or older? Does the patient have a diagnosis of cystic fibrosis with one mutation in the CFTR gene confirmed by a FDA-cleared CF mutation test or if the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use?	□Yes □No □Yes □No
Orkambi: Is the patient 1 years of age or older? Does the patient have a diagnosis of cystic fibrosis homozygous for the F508del mutation in the CFTR gene confirmed by an FDA-cleared CF mutation test?	□Yes □No □Yes □No
Symdeko: Is the patient 6 years of age or older**?** Does the patient have a diagnosis of cystic fibrosis homozygous for the F508del mutation in the CFTR gene confirmed by an FDA-cleared CF mutation test or have at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor based on in vitro data and/or clinical evidence or if the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use?	□Yes □No □Yes □No
Trikafta: Is the patient 2 years of age or older? Does the patient have a diagnosis of cystic fibrosis have at least one F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene confirmed by a FDA-cleared CF mutation test or if the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to confirm the presence of at least one F508del mutation or a mutation that is responsive based on in vitro data?	□Yes □No □Yes □No

If you answered 'NO' to either of the questions above corresponding to the requested medication above, a Letter of Medical Necessity (LMN) must be reviewed for consideration. Please provide all relevant information relating to the medical necessity (see Conn. Gen. Stat § 17b-259b(a)) for the requested Cystic Fibrosis medication for this patient. Submit request via email to rx.lmn@ct.gov.

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission.

I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1- to 17-83k-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the above-referenced member is a patient under my clinic's/practice's ongoing care. Authorizations for Early Refill Requests are valid one time only.

Prescriber Signature* :_____**Date (MM/DD/CCYY)**_____

* Mandatory (others may not sign for prescriber). **In accordance with federal law, prescribers must be enrolled in the Connecticut Medical Assistance Program (CMAP). CMAP will not pay for prescriptions written by a non-enrolled provider.**