STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES TELEPHONE: 1-866-409-8386 FAX:

1-866-759-4110 OR (860) 269-2035

(This and other PA forms are posted on www.ctdssmap.com and can be accessed by clicking on the pharmacy icon)

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

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 6 months 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?	□Yes □No □Yes □No
Orkambi: Is the patient 2 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?	□Yes□No □Yes □No
Trikafta: Is the patient 12 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?	□Yes □No □Yes □No

If you answered "No" to any of the questions above regarding the medication requested, please provide other information relating to the medical necessity (see Conn. Gen. Stat. § 17b-259b(a)) of this drug for this patient.

_____

_____

_____

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.

Signature of Prescriber* _____Date (MM/DD/CCYY)_____

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