TO: Pharmacy Providers, Physicians, Nurse Practitioners, Physician Assistants, Long Term Care Providers, Clinics, and Hospitals

RE: Updated Cystic Fibrosis (CF) Prior Authorization Request Form for Orkambi, Kalydeco and Symdeko

The purpose of this bulletin is to inform prescribing providers that effective May 1, 2018, Prior Authorization (PA) is required for prescription benefit coverage of Kalydeco and Symdeko for HUSKY A, HUSKY B, HUSKY C, and HUSKY D members.

Kalydeco (ivacaftor) is indicated for patients aged 2 and older who have one mutation in the Cystic Fibrosis Transmembrane Conductance Regulator (CFTR) gene that is responsive to drug treatment based on clinical and/or in vitro (laboratory) data.

Symdeko (tezacaftor/ivacaftor) is indicated for the treatment of patients with CF aged 12 years and older, who are homozygous for the F508del mutation, which causes the production of an abnormal protein that disrupts how water and chloride are transported in the body, or who have at least one mutation in the CFTR gene that is responsive to tezacaftor/ivacaftor based on in vitro data and/or clinical evidence.

Effective May 1, 2018, the updated Cystic Fibrosis PA Request Form must be used to request a PA for Orkambi, Kalydeco and Symdeko. The updated form replaces the Orkambi PA request form currently being used for Orkambi.

The Cystic Fibrosis PA form is attached below and will be available on the www.ctdssmap.com Web site. From the Home page, go to Information → Publications → Authorization/Certification Forms → Cystic Fibrosis PA Form; or Pharmacy Information → Pharmacy Program Publications → Cystic Fibrosis PA Form.

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 and Symdeko]

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 2 years of age of older?	□ Yes	□ No
Does the patient have a diagnosis of cystic fibrosis with one mutation in the CFTR gene that is responsive to ivacaftor based on clinical and/or in vitro assay data?	□ Yes	□ No
Orkambi:		
Is the patient 6 years of age of older?	□ Yes	□ No
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
Symdeko:		
Is the patient 12 years of age of older**?**	□ Yes	□ No
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

If you answered "No" to any of the questions above, 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. I understand that a prior authorization may not exceed six (6) months from the date of fill for controlled medications and one (1) year from the date of fill for non-controlled medications. 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 Assistance Program (CMAP). CMAP will not pay for prescriptions written by a non-enrolled provider.**