TO: Pharmacy Providers, Physicians, Nurse Practitioners, Physician Assistants, Long Term Care Providers, Clinics, and Hospitals
RE: New Prior Authorization Request Form for Orkambi

The purpose of this bulletin is to inform prescribing providers that, effective November 1, 2015, Prior Authorization (PA) is required for prescription benefit coverage of Orkambi for HUSKY A, HUSKY B, HUSKY C, and HUSKY D clients.

Orkambi (lumacaftor 200 mg/ivacaftor 125 mg) is approved by the U.S. Food and Drug Administration (FDA) as the first drug for cystic fibrosis (CF) directed at treating the cause of the disease in people who have two copies of a specific mutation.

Orkambi is approved to treat CF in patients 12 years and older, who have the F508del mutation, which causes the production of an abnormal protein that disrupts how water and chloride are transported in the body. Having two copies of this mutation (one inherited from each parent) is the leading cause of CF.

Effective November 1, 2015, the newly developed Orkambi PA Request Form must be used to request PA for Orkambi.

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

STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
PO BOX 2943 HARTFORD, CT 06104
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 **ORKAMBI** Prior Authorization (PA) Request Form
[To be used for the authorization of Orkambi]

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	
Quantity Requested:	Frequency of Dosing:
Pharmacy's Fax: ( )	

Clinical Information

Is the patient 12 years of age or 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 one or both of the questions above, please provide any 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.**