AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Lumacaftor/Ivacaftor (Orkambi™)

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:	Patient name:	
Patient address:		DOB:
Provider NPI:	Prescriber name:	Phone:
Prescriber address:		Fax:
Pharmacy name:		
Address:		Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI:	Pharmacy fax:	NDC:

Prior authorization is required for Orkambi™ (lumacaftor/ivacaftor). Dual therapy with another cystic fibrosis transmembrane conductance regulator (CFTR) potentiator will not be considered. Payment will be considered for patients when the following criteria are met: 1) Patient is 6 years of age or older; and 2) Has a diagnosis of cystic fibrosis; and 3) Patient is homozygous for the F508del mutation in the CFTR gene as confirmed by a FDA-cleared CF mutation test; and 4) Baseline liver function tests (AST/ALT) and bilirubin levels are provided; and 5) Prescriber is a CF specialist or pulmonologist.

If the criteria for coverage are met, an initial authorization will be given for 3 months. Additional approvals will be granted for 6 months at a time if the following criteria are met: 1) Adherence to lumacaftor/ivacaftor therapy is confirmed; and 2) Liver function tests (AST/ALT) and bilirubin are assessed every 3 months during the first year of treatment and annually thereafter.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

☐ Orkambi

Dosage Instructions: Quantity: Days Supply:

Initial Requests. Attach the following test results:

☐ FDA-cleared CF mutation test documenting patient is homozygous for the F508del mutation in the CFTR gene.

☐ Baseline liver function tests (AST/ALT) and bilirubin Result:

Prescriber specialty: ☐ CF Specialist ☐ Pulmonologist ☐ Other (specify):

Attach lab results and other documentation as necessary. Minimal required results to be submitted are the results of the gene mutation test and lab results.

Renewal Requests

Is patient adherent to Orkambi? ☐ Yes ☐ No

Liver function tests (AST/ALT) and bilirubin will be assessed every 3 months during the first year of treatment and annually thereafter?

☐ Yes (attach most recent results) Date and result: ☐ No

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Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further acknowledge that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
Prescriber signature: (Must match prescriber listed above.)	Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.