VERMONT
Department of Vermont Health Access
NOB 1 South, 280 State Drive
Waterbury, Vermont 05671-1010

~Cystic Fibrosis ~

Prior Authorization Request Form

In order for beneficiaries to receive Medicaid coverage for medications that require prior authorization, the prescriber must complete and fax this form to Change Healthcare. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information. For questions, please contact the Change Healthcare helpdesk at 1-844-679-5363.

Submit request via Fax: 1-844-679-5366

Prescribing physician:
Name: _____
Physician NPI: _____
Specialty: _____
Phone#: _____
Fax#: _____
Address: _____
Contact Person at Office: _____

Beneficiary:
Name: _____
Medicaid ID#: _____
Date of Birth: _____ Sex: _____
Patient's Phone: _____
Pharmacy Name_____
Pharmacy NPI: _____
Pharmacy Phone: _____Pharmacy Fax: _____

The following MUST be completed for MEDICAL BENEFIT requests:
HCPCS J-code or other code: _____
Administering Provider/Facility: Name_____ NPI#_____ Medicaid ID#_____

Please check box if this drug is being provided under the DVHA's 340B Drug program and requires the TB modifier ☐

Patient Diagnosis: ☐ Cystic Fibrosis ☐ Other: _____
(Requires Review by DVHA Medical Director)

Mucolytics:

☐ Pulmozyme® (dornase alfa inhalation) 1 mg/ml, 2.5 ml ampules
- ☐ Administer via nebulizer once daily Dispense# 30 Refill_____times
- ☐ Administer via nebulizer twice daily Dispense# 60 Refill_____times

Inhaled Antibiotics:

☐ TOBI® (tobramycin) Podhaler 28 mg capsules (capsules for use with Podhaler only)
Administer 4 capsules via Podhaler twice daily, alternating 28 days on and 28 days off

☐ TOBI® (tobramycin solution for inhalation) 300mg/5 ml ampules ☐ Tobramycin Solution for inhalation
☐ Bethkis®(tobramycin) Solution ☐ Kitabis® (tobramycin) Solution
Administer via nebulizer twice daily, alternating 28 days on and 28 days off

CFTR Gene Mutation Potentiators:

☐ Kalydeco® (ivacaftor) packets ☐ 50mg (less than 14kg) ☐ 75mg (greater than 14kg)

☐ Kalydeco® (ivacaftor) 150mg tablets
Directions_____

☐ Orkambi® (lumacaftor/ivacaftor) tablets ☐ 100/125mg ☐ 200/125mg

☐ Orkambi® (lumacaftor/ivacaftor) Packets ☐ 100/125mg (less than 14kg) ☐ 150/188mg (greater than 14kg)

Directions_____

CHANGE HEALTHCARE

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☐ Symdeko® (Tezacaftor/Ivacaftor & Ivacaftor) ☐ 50/75mg ☐ (100/150mg)

Directions_____

☐ Trikafta® (Elexacaftor/Tezacaftor/Ivacaftor & Ivacaftor)

Directions_____

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and/or recoupment.

Prescriber's Signature: _____ **Date:** _____

CHANGE HEALTHCARE