



Request for Prior Authorization

**CYSTIC FIBROSIS**

**AGENTS, ORAL**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Will requested medication be used with other CFTR modulator therapies?  No  Yes

**Trifakta Requests:**

Does patient have severe hepatic impairment (Child-Pugh Class C)?  No  Yes

**Renewal Requests:**

Patient is adherent to oral cystic fibrosis therapy:  Yes  No

Liver function tests (AST/ALT/bilirubin) are assessed every 3 months during first year of treatment and annually thereafter:  Yes  No Most recent lab date: \_\_\_\_\_

***Attach lab results and other documentation as necessary.***

Prescriber signature (Must match prescriber listed above.)	Date of submission
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**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 Health and Human Services, that the member continues to be eligible for Medicaid.*