Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

CFTR Modulators

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the drug being prescribed by or in consultation with a pulmonologist, endocrinologist, or pediatrician?

☐ Yes ☐ No

Q2. Does the patient have a confirmed diagnosis of cystic fibrosis?

☐ Yes ☐ No

Q3. Has appropriate genetic testing been conducted? Appropriate lab work must be attached.

☐ Yes ☐ No

Q4. GENETIC TESTING: For KALYDECO: Does genetic testing show the patient has one mutation in the CFTR gene that is responsive to ivacaftor based on clinical and/or in vitro assay data? For ORKAMBI: Does genetic testing show the patient is homozygous for the F508del mutation in the CFTR gene? For TRIKAFTA: Does genetic testing show the patient has at least one F508del mutation in the CFTR gene or a mutation in the CFTR gene that is responsive based on clinical and/or in vitro data? For SYMEDKO: Does genetic testing show the patient is homozygous for the F508del mutation or a mutation in the CFTR gene that is responsive based on clinical in/or in vitro data?

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Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q5. Has baseline liver function (including alanine aminotransferase [ALT], aspartate aminotransferase [AST] and bilirubin) been assessed prior to initiation of treatment? Labs must be attached.

☐ Yes ☐ No

Q6. Is there documentation of inadequate response, intolerance, or contraindication to all formulary agents indicated for the patient's diagnosis?

☐ Yes ☐ No

Q7. Additional Information:

_____ _____

Prescriber Signature Date

v2025