Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

CFTR Modulators

Phone: 215-991-4300 **Fax back to: 866-371-3239**

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.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	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 applying the 72 hour 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. 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?

☐ Yes ☐ No

Q5. For Orkambi: Does genetic testing show the patient is homozygous for the F508del mutation in the CFTR gene?

☐ Yes ☐ No

Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

CFTR Modulators

Phone: 215-991-4300 **Fax back to: 866-371-3239**

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.

Member Name:	**Prescriber Name:**

Q6. 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?

☐ Yes ☐ No

Q7. 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

Q8. Requested Duration:

☐ 12 months ☐ Other

Q9. Additional Information:

Prescriber Signature Date

v2026