



**Montana Medicaid Prior Authorization Request Form for Use of
Orkambi® (lumacaftor/ivacaftor)**

Patient Name:	Date:
Patient Medicaid ID:	DOB:
Prescriber Name:	Specialty:
Prescriber Phone:	Prescriber Fax:

Please complete below information for applicable situation, Initiation or Continuation of therapy:

INITIATION OF THERAPY

- Patient is 6 years of age or older. Yes No
- Laboratory results are attached confirming that patient is homozygous for the F508del mutation in the cystic fibrosis transmembrane regulator (CFTR) gene. Yes No
- Prescriber is a pulmonologist specializing in the treatment of Cystic Fibrosis. Yes No
- Provide baseline percent predicted expiratory volume (ppFEV₁): _____ Date: _____
- History of pulmonary exacerbations within the past 12 months is provided:

Initial authorization will be issued for 6 months.

CONTINUATION OF THERAPY

- Date medication started: _____
- Provider attests that in comparison to baseline, the patient has achieved a clinically meaningful response while on Orkambi® therapy to one or more of the following:
 - Lung function improvement as demonstrated by improvement or stability in ppFEV₁. Yes No
 - Provide current ppFEV₁: _____ Date: _____
 - Decline in pulmonary exacerbations. Yes No
 - Stability or increase in body mass index (BMI). Yes No
- Prescriber is a pulmonologist specializing in the treatment of Cystic Fibrosis. Yes No

Reauthorization will be issued for 12 months.

Please complete form, including required attachments and fax to:
Medicaid Drug Prior Authorization Unit
1-800-294-1350