Fax completed form to Navitus at: 855-668-8553
For questions, please call: 877-908-6023

TEXAS MEDICAID

Drug Prior Authorization
Cystic Fibrosis Agents: elexcaftor/tezacaftor/ivacaftor (TRIKAFTA)

Request Information (required)
This request is: ☐ **Expedited* (Urgent)** ☐ **Standard (Non-Urgent)** *Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

Member Information (required)			Prescriber Information (required)		
Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :	Specialty:	
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Please fill out the following information:

1. Medication Requested (Name):
(Go to #2)

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Required Criteria

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

Clinical Criteria (required)

6. Is the member greater than or equal to (≥) two (2) years of age?

- ◯ Yes
(Go to #7)
- ◯ No (Deny)
(Go to #7)

7. Manual Step - Does the member have a diagnosis of cystic fibrosis and at least one F508del mutation in the Cystic Fibrosis Transmembrane Conductance Regulator (CFTR) gene OR a mutation in the CFTR gene that is responsive to elexacaftor/tezacaftor/ivacaftor based on *in vitro* data? If the genotype is unknown, a United States Food and Drug Administration (FDA) cleared cystic fibrosis mutation test should be used to detect the presence of a CFTR mutation.

- ◯ Yes
  (Go to #8)
- ◯ No (Deny)
  (Go to #8)

8. Does the member have a diagnosis of severe hepatic impairment in the last 365 days?

- ◯ Yes (Deny)
  (Go to #9)
- ◯ No
  (Go to #9)

9. Does the member have a claim for a CYP3A4 inducer in the last 45 days?

   Examples of CYP3A4 inducers include: APTIOM, armodafinil (NUVIGIL), ATRIPLA, BANZEL, bexarotene (TARGETIN), bosentan (TRACLEER), carbamazepine (CARBATROL, EPITOL, EQUETRO, TEGRETOL), clobazam (ONFI, SYMPAZAN), dexamethasone, dicloxacillin, efavirenz (SUSTIVA), INTELENCE, LYSODREN, modafinil (PROVIGIL), nevirapine (VIRAMUNE), ORILISSA, ORKAMBI, oxcarbazepine (TRILEPTAL, OXTELLAR), phenobarbital, phenytoin (DILANTIN, PHENYTEK), PRIFTIN, primidone (MYSOLINE), rifabutin (MYCOBUTIN), rifampin (RIFADIN), RIFATER, SYMFI, TAFINLAR, XERMELO, XTANDI, and ZELBORAF.

- ◯ Yes (Deny)
  (Go to #10)
- ◯ No
  (Go to #10)

10. Is the requested quantity greater than (>) 84 tablets per 28 days?

- ◯ Yes (Deny)
  (Go to #11)
- ◯ No
  (Go to #11)

11. Will the member have concurrent therapy with KALYDECO, ORKAMBI, or SYMDEKO?

- ◯ Yes (Deny)
  (Go to #12)
- ◯ No (Approve - 365 days)
  (Go to #12)

Additional Information

12. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

**** PLEASE FAX COMPLETED FORM TO: 855-668-8553 ****

If criteria not met, submit chart documentation with form citing complex medical circumstances.
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