Health Partners Plans

HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Orkambi - Medicare

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

Health Partners 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: □ Medicare	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 Orkambi being prescribed by a pulmonologist, endocrinologist, or pediatrician?

☐ Yes ☐ No

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

☐ Yes ☐ No

Q3. Is the patient 2 years of age or older?

☐ Yes ☐ No

Q4. Has appropriate genetic testing been conducted showing the patient is homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene?
Please attach appropriate lab work.

☐ Yes ☐ No

Q5. Have 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. Additional Information:

Q7. Requested Duration:

☐ 12 months

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Patient Name:	**Prescriber Name:**

Prescriber Signature

Date

2021 Medicare Prior Authorization Request