US Family Health Plan
Prior Authorization Request Form for
elexacaftor - tezacaftor - ivacaftor **(Trikafta)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is the requested medication being prescribed by or in consultation with a pulmonologist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is Trikafta being prescribed for the treatment of cystic fibrosis (CF)?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is this drug being requested for an FDA approved age?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient have at least one F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene as detected by an FDA-approved CF mutation test?	☐ Yes Proceed to question **6**	☐ No Proceed to question **5**
5. Does the patient have a mutation in the CFTR gene that is responsive based on in vitro data?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is the genotype known or unknown?	☐ Known - Proceed to question **8** ☐ Unknown - Proceed to question **7**	
7. Has an FDA-approved test been used to detect the presence of at least one F508del mutation or a mutation that is responsive based on in vitro data?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**

	8. Is this agent being used in combination therapy with Symdeko, Orkambi or Kalydeco?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____

[09 June 2021]