Prescriber Criteria Form

Orkambi 2025 PA Fax 1279-A v1 010125.docx
Orkambi (lumacaftor/ivacaftor)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-663-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Orkambi (lumacaftor/ivacaftor).

Drug Name:
Orkambi (lumacaftor/ivacaftor)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of cystic fibrosis? [If no, then no further questions.]	Yes ◯	No ◯
2	Does the patient have the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene? [If no, then no further questions.]	Yes ◯	No ◯
3	Is the patient positive for the F508del mutation on both alleles of the cystic fibrosis transmembrane conductance regulator (CFTR) gene? [If no, then no further questions.]	Yes ◯	No ◯
4	Will the requested medication be used in combination with other medications containing ivacaftor? [If yes, then no further questions.]	Yes ◯	No ◯
5	Is the patient 1 year of age or older?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ Date:_____