Prescription Medication Prior Authorization Request Form

☐ Standard PA Request ☐ Urgent/Expedited PA Request

Please fill out all sections and attach any important documentation such as chart notes or lab results to support the PA request.
Once completed, submit to WithMe Health via fax at **1-866-678-8301**

Patient Information

Patient Name (Last, First, MI):		
Member ID Number:	Date of Birth:	Patient Phone Number:
Patient Address:		
Patient's Authorized Representative (If applicable):		Authorized Rep Phone Number:

Provider Information

Requesting Provider's Name:		
NPI:	Specialty:	
Office Address:		
Office Phone:	Office Fax:	
Office Contact Name:	Phone:	Fax:
Dispensing Pharmacy Name/Place of Service:	Phone:	Fax:

Requested Medication Information

Medication Name and Strength:	
Dose and Frequency (Sig):	
Qty Per 30 Days:	Expected Duration of Therapy:
ICD-10(s):	Diagnosis:

Please check one of the boxes below. If established, please include therapy start date:

☐ New Therapy ☐ Samples ☐ Clinical Trial ☐ Established Date Therapy Started: _____

Previous Therapies Used for Diagnosis (Rx and OTC products)

Medication Name, Strength, Dose, Frequency	Dates Used	Outcome of Therapy (e.g., Ineffective, Not Tolerated)

Medical Rationale for Use of Requested Medication (**Please attach chart notes, lab work etc. when submitting this request. If applicable, please include why formulary therapies may be contraindicated for this patient.** Please also include which therapies will be used along with the requested medication. If patient is established on the requested medication, please include recent documentation of how the patient has responded to therapy.):

Disease State Specific Questions

If the diagnosis is cystic fibrosis, please provide the following information:

1. Is the drug being requested Kalydeco® (ivacaftor), Orkambi® (lumacaftor/ivacaftor), Symdeko® (tezacaftor/ivacaftor) Or Trikafta® (elexacaftor/tezacaftor/ivacaftor)? ☐ Yes ☐ No
2. Was the diagnosis of cystic fibrosis (CF) is established by, or in consultation with a pulmonologist? ☐ Yes ☐ No
3. What is the age of the patient? _____
4. Has a genetic test been performed on the patient? ☐ Yes ☐ No
5. If so, please indicate what genetic mutation was identified
   - ☐ Genetic testing that confirms at least one CFTR gene mutation responsive to Kalydeco based on in vitro data and/or clinical evidence. Some mutations include but are not limited to:
     711+3A →G, 2789+5G→A, 3272-26A→G,
     3849+10kbC→T, A455E, A1067T, D110E, D110H, D579G, D1152H, D1270N, E56K, E193K, E831X, F1052V, F1074L, G178R, G551D, G551S, G1069R, G1244E, G1349D, K1060T, L206W, P67L, R74W, R117C, R117H, R347H, R352Q, R1070Q, R1070W, S549N, S549R, S945L, S977F, S1251N, S1255P
   - ☐ Genetic testing that confirms two copies (homozygous) for the F508del mutation.
   - ☐ Genetic testing that confirms:
     Two copies (homozygous) for the F508del mutation.
     OR
     At least one of CTRF gene mutation responsive to Symdeko based on in vitro data and/or clinical evidence. Some mutations include but are not limited to:
     A455E, A1067T, D110E, D110H, D579G, D1152H, D1270N, E56K, E193K, F1052V, F1074L, K1060T, L206W, P67L, R74W, R117C, R347H, R352Q, R1070W, S945L, S977F
   - ☐ Genetic testing that confirms:
     One copy for the F508del mutation.
     OR
     At least one CTRF gene mutation responsive to Trikafta based on in vitro data. Some mutations include but are not limited to:
     A455E, A1067T, D110E, D110H, D579G, D1152H, D1270N, E56K, E193K, F1052V, F1074L, K1060T, L206W, P67L, R74W, R117C, R347H, R352Q, R1070W, S945L, S977F

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by WithMe Health, the health plan sponsor, or, if applicable, a state or federal regulatory agency.

_____ _____

Provider Signature Date