UnitedHealthcare Community Plan

Cystic Fibrosis Agents, Oral - Washington
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

UnitedHealthcare Community Plan

Cystic Fibrosis Agents, Oral - Washington
Prior Authorization Request Form

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS:

- Does the patient have a diagnosis of cystic fibrosis? □ Yes □ No

- Has the patient demonstrated failure or intolerance to a majority of the preferred oral Cystic Fibrosis agents? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- Does the patient have confirmation of 2 copies of the F508del mutation in the CFTR gene (i.e. the patient is homozygous for the F508del mutation)? □ Yes □ No

- Does the patient have documentation of at least ONE mutation in the CFTR gene that is responsive to the requested medication potentiation? □ Yes □ No

A1067T *c.3199G>A*	*G1244E* *c.3731G>A*	*R352Q* *c.1055G>A*
A455E *c.1364C>A*	*G1349D* *c.4046G>A*	*R74W* *c.220C>T*
D110E *c.330C>A*	*G178R* *c.532G>A*	*S1251N* *c.3752G>A*
D110H *c.328G>C*	*G551D* *c.1652G>A*	*S1255P* *c.3763T>C*
D1152H *c.3454G>C*	*G551S* *c.1651G>A*	*S549N* *c.1646G>A*
D1270N *c.3808G>A*	*K1060T* *c.3179A>C*	*S549R* *c.1645A>C,* *c.1647T>G*
D579G *c.1736A>G*	*L206W* *c.617T>G*	*S945L* *c.2834C>T*
E193K *c.577G>A*	*P67L* *c.200C>T*	*S977F* *c.2930C>T*
E56K *c.166G>A*	*R1070Q* *c.3209G>A*	*2789+5G→A* *c.2657+5G>A*
E831X *c.2491G>T*	*R1070W* *c.3208C>T*	*3272-26A→G* *c.3140-26A>G*
F1052V *c.3154T>G*	*R117C* *c.349C>T*	*3849+10kbC→T* *c.3718-2477C>T*
F1074L *c.3222T>A*	*R117H* *c.350G>A*	*711+3A→G* *c.579+3A>G*
G1069R *c.3205G>A*	*R347H* *c.1040G>A*	*F508del/F508del* *c.1521_1523delCTT*

Requests for CONTINUATION OF THERAPY:

- Does the patient meet one of the following: □ Yes □ No (check which applies)

□ FEV_1 has significantly improved from baseline

□ Stabilization of disease

Provider Signature: _____ **Date:** _____