Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Trikafta (Elexcaftor/Tezacaftor/Ivacaftor) (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Trikafta (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)
TRIKAFTA 100/50/75MG-150MG

Patient Information	
Patient Name:	
Patient ID:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:
Directions for administration:	

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   If the answer to this question is yes, approved for 365 days.
   If the answer to this question is no, go to question 2.

2. Is the patient greater than or equal to 12 years of age? Y N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, denied.

3. Does the patient have a diagnosis of cystic fibrosis and at least one F508del mutation in the CFTR gene OR a mutation in the CFTR gene that is responsive to elexacaftor/tezacaftor/ivacaftor based on in vitro data? If the genotype is unknown, an FDA-cleared cystic fibrosis mutation test should be used to detect the presence of a CFTR mutation. Y N
   If the answer to this question is yes, go to question 4.
   If the answer to this question is no, denied.

4. Does the patient have a diagnosis of severe hepatic impairment in the last 365 days? Y N

If the answer to this question is yes, denied.
If the answer to this question is no, go to question 5.

5. Does the patient have a claim for a CYP3A4 inducer in the last 45 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 6.

6. Does the patient have a claim for a strong CYP3A4 inhibitor in the last 45 days? Y N
If the answer to this question is yes, go to question 8.
If the answer to this question is no, go to question 7.

7. Does the patient have a claim for a moderate CYP3A4 inhibitor in the last 45 days? Y N
If the answer to this question is yes, go to question 9.
If the answer to this question is no, go to question 10.

8. Is the daily dose adjusted for co-administration with a strong CYP3A4 inhibitor (see table below? Y N
If the answer to this question is yes, go to question 11.
If the answer to this question is no, denied.

Co-administration with:	Recommended Trikafta Dosing:
Strong CYP3A4 Inhibitor	Less than or equal to (≤) 20 tablets per 28 days OR ≤0.72 units/day when calculated, if days supply exceeds 28

9. Is the daily dose adjusted for co-administration with a moderate CYP3A4 inhibitor (see table below)? Y N
If the answer to this question is yes, go to question 11.
If the answer to this question is no, denied.

Co-administration with:	Recommended Trikafta Dosing:
Moderate CYP3A4 Inhibitor	Less than or equal to (≤) 42 tablets per 28 days OR ≤ 1.5 units/day when calculated, if days supply exceeds 28

10. Is the requested quantity greater than 84 tablets per 28 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 11.

11. Will the patient have concurrent therapy with Kalydeco, Orkambi or Symdeko? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 12.

12. Is this request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 13.
If the answer to this question is no, approved for 365 days.

13. Has the patient failed a treatment trial with at least 1 preferred agent? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, go to question 14.

14. Is there a documented allergy or contraindication to preferred agents in this class? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, denied.

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (or Authorized) Signature

Date