Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Orkambi® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			**Provider Information (required)**		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Cystic fibrosis (CF)

❑ Other diagnosis: ____ ICD-10 Code(s): __________________________

Clinical information:

Does the patient have a laboratory confirmation of homozygous F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene? ❑ **Yes** ❑ **No**

Was the requested medication prescribed by or in consultation with a pulmonologist or specialist affiliated with a CF care center? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.

Office use only: Orkambi_SouthDakotaMedicaid_2018Sep-P