SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Alyftrek™ (vanzacaftor/tezacaftor/deutivacaftor)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Recommended Dosing:

- **Children ≥ 6 years to < 12 years weighing < 40 kg:** Oral: Three tablets of vanzacaftor 4 mg/tezacaftor 20 mg/deutivacaftor 50 mg once daily
- **Children ≥ 6 years to < 12 years weighing ≥ 40 kg:** Oral: Two tablets of vanzacaftor 10 mg/tezacaftor 50 mg/deutivacaftor 125 mg once daily
- **12 years and older:** Oral: Two tablets of vanzacaftor 10 mg/tezacaftor 50 mg/deutivacaftor 125 mg once daily

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 12 months

- ❑ Member has a diagnosis of Cystic Fibrosis

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- ❑ Member is 6 years of age or older
- ❑ Member has **at least one** variant in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is either responsive based on clinical and/or in vitro data or results in production of CFTR protein, as confirmed by an FDA-cleared CF mutation test **(Test results must be attached)**
- ❑ Baseline liver function tests (e.g., ALT, AST, bilirubin) have been performed and will be reassessed and monitored regularly during treatment (every month for first 6 months, every 3 months for next 12 months, then at least annually) **(Test results must be attached)**
- ❑ Member does **NOT** have severe hepatic impairment (Child-Pugh Class C)
- ❑ Member will **NOT** be taking Alyftrek™ in combination with any other CFTR modulator therapy (i.e., Trikafta®, Symdeko®, Orkambi®, or Kalydeco®) **NOTE**: Concurrent therapy with these agents will **NOT** be approved

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member continues to meet initial criteria
- ❑ Member continues to experience clinical benefit from the requested treatment

Medication being provided by Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

***Approved by Pharmacy and Therapeutics Committee**: 3/27/2025
REVISED/UPDATED/REFORMATTED:06/26/26