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Kalydeco (Ivacaftor) Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004.
Provider Help Desk: 1-800-454-3730

1. Patient information	**2. Physician information**
Patient name:_____	Prescribing physician:_____
Patient ID #: _____	Physician address: _____
Patient DOB:_____	Physician phone #: _____
Date of Rx: _____	Physician fax #:_____
Patient phone #:_____	Physician specialty:_____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
Kalydeco	_____	_____	Specify: _____

7. Diagnosis:_____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization is required for Kalydeco™ (ivacaftor). Payment will be considered for patients when the following criteria are met:

1. Patient meets the FDA approved age; and
2. Patient has a diagnosis of cystic fibrosis; and
3. Patient has one of the CFTR gene mutations as indicated in the FDA approved label as detected by an FDA-cleared CF mutation test; and
4. Prescriber is a CF specialist or pulmonologist; and
5. Baseline liver function tests (AST/ALT) are provided.

If the criteria for coverage are met, an initial authorization will be given for 3 months. Additional approvals will be granted for 6 months at a time if the following criteria are met:

1. Adherence to Ivacaftor therapy is confirmed; and
2. Liver function tests (AST/ALT) are assessed every 3 months during the first year of treatment and annually thereafter.

Diagnosis (Attach a copy of FDA-cleared CF mutation test results): _____
Attach a copy of baseline liver function test (AST/ALT).
Prescriber specialty: ☐ CF specialist ☐ Pulmonologist ☐ Other (specify) _____

Renewal requests:
Patient is adherent to Ivacaftor therapy: ☐ Yes ☐ No

Liver function tests (AST/ALT) are assessed every 3 months during first year of treatment and annually thereafter:
☐ Yes
☐ No. Most recent lab date: _____
Ivacaftor therapy start date: _____

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____
Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.