

Prior Authorization Request Form for ivacaftor (Kalydeco)



7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

**FAX Completed Form and
Applicable Progress Notes to:
(410) 424-4037**

To be completed by Requesting provider	
Drug Name: _____	Strength: _____
Dosage/Frequency (SIG): _____	Duration of Therapy: _____

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID #: _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

1. Is Kalydeco being used for the treatment of cystic fibrosis (CF)?	<input type="checkbox"/> Yes Proceed to Question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Is the patient's age appropriate according to the FDA approved indication of Kalydeco?	<input type="checkbox"/> Yes Proceed to Question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Is the patient homozygous for the F508del mutation in the CFTR gene?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to Question 4
4. Does the patient have a specific CF-related gene mutation that has been detected by an FDA-approved test?	<input type="checkbox"/> Yes Proceed to Question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Will Kalydeco be used concomitantly with Orkambi or Symdeko?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to Question 6
6. What is the gene mutation? <i>Prescriber please document</i> <i>the gene mutation:</i> _____	Sign and date below	

CFTR = cystic fibrosis transmembrane conductance regulator

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Step I certify the above is true to the best of my knowledge. Please sign and date:

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Prescriber Signature

Date

[29 May 2019]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: