



Request for Prior Authorization
IVACAF TOR (KALYDECO™)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Prescriber must complete all information above, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for Kalydeco™ (ivacaftor). Payment will be considered for patients when the following criteria are met: 1) Patient is 2 years of age or older; and 2) Has a diagnosis of cystic fibrosis with one of the following mutations in the CFTR gene: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, S549R, and R117H as detected by an FDA-cleared CF mutation test; and 3) Prescriber is a CF specialist or pulmonologist; and 4) Baseline liver function tests (AST/ALT) and FEV1, if age appropriate, are provided; and 5) Patient does not have one of the following infections documented on the most recent sputum culture: Burkholderia cenocepacia, Burkholderia dolosa, Mycobacterium abscessus. 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) Response to therapy is documented by prescriber (e.g., improved FEV1 from baseline, decreased exacerbations, improved quality of life) or rationale for continued care; and 3) Liver function tests (AST/ALT) are assessed every 3 months during the first year of treatment and annually thereafter.

[] Kalydeco™

Strength Dosage Instructions Quantity Days Supply

Diagnosis (Attach copy of FDA-cleared CF mutation test results):

Attach copy of baseline liver function test (AST/ALT) and FEV1 or indicate why not appropriate:

Prescriber Specialty: [] CF Specialist [] Pulmonologist [] Other (specify):

Most recent sputum culture negative for Burkholderia cenocepacia, Burkholderia dolosa, Mycobacterium abscessus: Date: (please attach copy of results)

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Renewal Requests:

Patient is adherent to ivacaftor therapy: Yes No

Document response to therapy (improved FEV₁ from baseline, weight increased from baseline, decreased exacerbations, improved quality of life) or rationale for continued care. Please provide labs, if applicable, and specific documentation of improvement: _____

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.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.