PRIOR AUTHORIZATION REQUEST
Kalydeco

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. ☐ Yes ☐ No Does the patient have cystic fibrosis (CF)?
2. ☐ Yes ☐ No Is the patient homozygous for the phe508del (F508del) mutation in the cystic fibrosis transmembrane regulator (CFTR) gene?
3. ☐ Yes ☐ No Does the patient have at least one of the following mutations in the cystic fibrosis transmembrane conductance regulator (CFTR) gene: E56K, P67L, R74W, D110E, D110H, R117C, E193K, L206W, R347H, R352Q, A455E, D579G, S945L, S977F, F1052V, K1060T, A1067T, G1069R, R1070Q, R1070W, F1074L, D1152H, D1270N, G551D, G178R, S549N, S549R, G551S, G1244E, S1251N, S1255P, G1349D, 2789+5G-->A, 3272-26A-->G, 3849+10kbC-->T, 711+3A-->G, E831X, OR R117H?
4. ☐ Yes ☐ No Is the requested medication being prescribed by, or in consultation with, a pulmonologist or a physician who specializes in the treatment of cystic fibrosis (CF)?
5. ☐ Yes ☐ No Will the patient be taking the requested medication in combination with Orkambi, Symdeko, or Trikafta?

Please document the diagnoses, symptoms, and/or any other information important to this review:

_____

_____

SECTION B Physician Signature

_____
PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

If you have any questions, call: 800-753-2851

PRIOR AUTHORIZATION REQUEST

Kalydeco

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

If you have any questions, call:
800-753-2851