PRIOR AUTHORIZATION REQUEST

Kalydeco

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1	Does the patient have cystic fibrosis (CF)? [If no, no further questions.]	Yes	No
2	Is the patient homozygous for the phe508del (F508del) mutation in the cystic fibrosis transmembrane regulator (CFTR) gene? [If yes, no further questions.]	Yes	No
3	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,		

If you have any questions, call: 1-888-258-8250

maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

	G1349D, 2789+5G-->A, 3272-26A-->G, 3849+10kbC-->T, 711+3A-->G, E831X, OR R117H? [Note: If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use. Kalydeco is not approved in patients homozygous for the F508del mutation in the CFTR gene.] [] Yes (If checked, go to 4) [] No (If checked, no further questions) [] Unknown (If checked, no further questions)		
4	How old is the patient? [] Greater than or equal to 1 month of age (If checked, go to 5) [] Other (If checked, no further questions)		
5	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)? [If no, no further questions.]	Yes	No
6	Will the patient be taking the requested medication in combination with Orkambi, Symdeko, or Trikafta?	Yes	No

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: 1-833-896-0656

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: 1-888-258-8250

PRIOR AUTHORIZATION REQUEST