

## Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **KALYDECO (Ivacaftor.** <u>Please</u> <u>complete all sections, incomplete forms will delay processing.</u> <u>Fax this form back to Kaiser Permanente within 24 hours</u> <u>fax: 1-866-331-2104</u>. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.** 

KP-MAS Formulary can be found at: <u>http://www.providers.kaiserpermanente.org/mas/formulary.html</u>

1 – Patient Information							
Patient Name:	Kaiser Medical ID#:	Date of Birth:					
	2 – Prescriber Information						
Prescriber Name:	Specialty:	NPL					
	Prescriber Fax #:						
	3 – Pharmacy Information						
Pharmacy Name:	Pharmacy NPI:						
Pharmacy Phone #	Pharmacy Fax #:						
Drug 1: Name/Strength/Formulation:							
Drug 2: Name/Strength/Formulation:							

- 1. Is this request for initial or continuing therapy?
- Initial therapy
  Continuing therapy, State date: \_\_\_\_\_\_
- 2. Indicate the Member's diagnosis for the requested medication: \_\_\_\_\_\_
- 3. Is the member ≥6 months of age? AND □ No □ Yes
- 4. Member is NOT homozygous for the F508del mutation in the CFTR gene, AND □ No □ Yes
- 5. Does the member have at least one of the following mutations in the CFTR gene?

P67L	R117C	R347H	E831X	K1060T	R1070W	S1251N	2789+5G <b>→</b> A
R74W	G178R	R352Q	S945L	A1067T	F1074L	S1255P	3272-26A→G
D110E	E193K	A455E	S977F	G1069R	D1152H	D1270N	3849+10kbC→T
D110H	L206W	S549N	F1052V	R1070Q	G1244E	G1349D	711+3A <b>→</b> G
						E56K	

🗆 No 🗆 Yes

-OR-

6. Members with a R117H mutation in the CFTR gene who have clinically significant disease (patients with RII7H and the 5T form of the poly-T tract, but not 7T or 9T)

 No 
 Yes

## For Continuation of Therapy, Please Respond to Additional Questions Below:

- Was there documentation of positive clinical response? AND
   □ No □ Yes
- Did the specialist follow-up occur in the past 12 months? AND
   AST, ALT, bilirubin and ophthalmic changes (patients up to 17 years) are monitored at least annually
   No 
   Yes

## 6 – Prescriber Sign-Off

Additional Information – Please submit chart notes/medical records for the patient that are applicable to this request. Provide any additional supporting information that should be taken into consideration:

## I certify that the information provided is accurate. Supporting documentation is available for State audits.

**Prescriber Signature:** 

Date:

Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility