Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
KALYDECO (Ivacaftor) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **KALYDECO (Ivacaftor.** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. 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: http://www.providers.kaiserpermanente.org/mas/formulary.html

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5– Diagnosis/Clinical Criteria

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→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→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:

1. Was there documentation of positive clinical response? **AND**
   □ No □ Yes
2. 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:**