

Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: Medicare Part B Medicare Part D
 This request is: Expedited request Standard request

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Kalydeco[®] (ivacaftor)

Member

Last Name: _____ First Name: _____
 ID #: _____ DOB: _____ Gender: _____
 Primary Care Physician: _____
 Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____
 Provider Address: _____
 Provider NPI: _____ Contact Name: _____
 Provider Signature: _____ Date: _____

Product Information

New request Continuation request

Drug product: Kalydeco 150 mg tablet **Start date** (or date of next dose): _____
 Kalydeco 75 mg oral granules **Date of last dose** (if applicable): _____
 Kalydeco 50 mg oral granules **Dosing frequency:** _____

Precertification Requirements

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

1. Must be used for cystic fibrosis associated with one mutation in the CFTR gene that is responsive to Kalydeco
2. Must be age 2 or older

Medically accepted indication

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — or — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- Cystic fibrosis
 Other – the patient’s condition is: _____
Rationale for use: _____

A. What mutation in the CFTR gene does the patient have?

- | | | |
|---------------------------------|---------------------------------|--------------------------------------|
| <input type="checkbox"/> G551D | <input type="checkbox"/> G551S | <input type="checkbox"/> S549N |
| <input type="checkbox"/> G1244E | <input type="checkbox"/> R117H | <input type="checkbox"/> S1255P |
| <input type="checkbox"/> G1349D | <input type="checkbox"/> S1251N | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> G178R | <input type="checkbox"/> S1255P | |

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? Yes No

If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Kalydeco likely be the most effective option for this patient?

Yes No

If yes, please explain why: _____

If the patient is currently using Kalydeco, would changing the patient’s current regimen likely result in adverse effects for the patient?

Yes No

If yes, please explain: _____

