PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☐ **Commercial Individual (Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

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
- ☐ Kalydeco 75 mg oral granules
- ☐ Kalydeco 50 mg oral granules
- ☐ Kalydeco 25 mg oral granules

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Drug cost information

The wholesale acquisition cost for each Kalydeco tablet is $426.72. The annual cost of treatment with this drug is more than $311,500.

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Must be used for treatment of cystic fibrosis, and
2. Must have laboratory confirmation for any one of the approved mutations in the CFTR gene
3. Formulation requested must match FDA label for age (6 months to 5 years for the oral granules and at least 6 years for the oral tablet)

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 09/2019
Last reviewed 09/2019

Priority Health Precertification Documentation

A. What is the patient's diagnosis?

☐ Cystic fibrosis
☐ *Other:* _____
Rationale for use: _____

B. Which of the following mutations does the patient have? (please fax laboratory confirmation)

☐ E56K	☐ F1052V	☐ L206W	☐ S1251N
☐ A1067T	☐ F1074L	☐ P67L	☐ S1255P
☐ A455E	☐ G1069R	☐ R1070Q	☐ S549N
☐ D110E	☐ G1244E	☐ R1070W	☐ S549R
☐ D110H	☐ G1349D	☐ R117C	☐ S945L
☐ D1152H	☐ G178R	☐ R117H	☐ S977F
☐ D1270N	☐ G551D	☐ R347H	☐ E831X
☐ D579G	☐ G551S	☐ R352Q	☐ 711+3A→G
☐ E193K	☐ K1060T	☐ R74W	☐ 2789+5G→A
☐ 3272-26A→G	☐ 3849+10kbC→T		

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