OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

Drug Requested: **Kalydeco®** (ivacaftor)

***DRUG INFORMATION:* Complete all information below or authorization process will be delayed.**

Drug Form/Strength/Quantity: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ ***ICD Code, if applicable*:** _____

Kalydeco® will NOT be covered for patients with $FEV_1 \geq 90$ % initiation.

CLINICAL CRITERIA:* *ALL lines must be completed to ensure authorization process will NOT be delayed. Include all labs and attach with this request.

- ❑ Patient is 2 years of age or older with a diagnosis of Cystic Fibrosis
- ❑ Patient is confirmed to have at least one of the following mutations in the Cystic Fibrosis Transmembrane Regulator (CFTR) gene: **G551D, G1224E, G1349D, G178R, G551S, S1251N, S1255P, S549N, or S549R** ***(Laboratory documentation required.)***
- ❑ Patient confirmed to have an R117H mutation in the CFTR gene. ***(Laboratory documentation required.)***
- ❑ Member is currently on at least ***two (2)*** of the following:
  - ❑ Dornase alfa ❑ Hypertonic saline ❑ Inhaled or oral antibiotics within the last 3 months continuous

Initial Authorization **Limit to *6 months*. For *Re-authorization* member must show improvement from baseline of at least FEV1 7% and Sweat Chloride <60mmol/liter**	
Baseline Date: _____ ***(within 3months prior to Kalydeco)***	**Re-Authorization Date**: _____
FEV1: _____	**FEV1**: _____
Baseline Weight: _____	
Sweat Chloride: _____	**Sweat Chloride**: _____

***Medication being provided by a Specialty Pharmacy:* Sentara Norfolk General CM Pharmacy**

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: 7/1/2018