OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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 below. If incomplete, 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: Complete below. ALL lines must be completed to qualify. Include all labs. If incomplete, authorization will be delayed.

- ❑ 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: ❑ **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: ~~8/1/2017;~~ **8/31/2017**;