Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Kalydeco® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Cystic fibrosis

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Select if the patient is confirmed to have the following mutations in the cystic fibrosis transmembrane regulator (CFTR) gene:

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

Laboratory documentation of the above is required

Select if the patient is currently on the following therapies:

❑ Dornase alfa (Pulmozyme) ❑ Hypertonic saline ❑ Inhaled or oral antibiotics within the last 3 months continuously

Reauthorization:

If this is a reauthorization, answer the following questions:

Does the patient show improvement from baseline FEV1? ❑ **Yes** ❑ **No**

Baseline FEV1: _____ % Date: _____

Current FEV1: _____ % Date: _____

Document the patient's sweat chloride: _____ mmol/liter

Baseline date (within 3 months prior to Kalydeco), re-authorization date, baseline weight, and lab notes for FEV1 and sweat chloride must be provided

Medication being provided by: (Please check applicable box below)

❑ PropriumRx ❑ Specialty Pharmacy (specify name): _____

****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.

Prescriber Signature: _____ **Date:** _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.