Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Kalydeco (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-844-242-0908**.
When conditions are met, we will authorize the coverage of Kalydeco (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Kalydeco (ivacaftor)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Has this plan authorized Kalydeco in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 4.]

2. Has documentation been submitted to support a response to therapy (symptom improvement and/or stable FEV1)? Y N

   If yes, please document response or submit records:

   _____

   [If no, then no further questions.]

3. Will therapy be temporarily discontinued if the patient's AST or ALT levels are greater than 5 times the upper limit of normal? Y N

   [No further questions.]

4. Does the patient have a diagnosis of cystic fibrosis? Y N

   [If no, then no further questions.]

5. Does the patient have one of the CFTR gene mutations: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, S549R, or R117H (or other mutations per the prescribing information? Y N

   [If no, then no further questions.]

6. Is the patient homozygous for the F508del mutation in the CFTR gene? Y N

   [If yes, then no further questions.]

7. Is the patient 2 years of age or older? Y N

   [If no, then no further questions.]

8. Have liver function tests been evaluated and the prescribed dose reduced if the patient has moderate to severe hepatic impairment? Y N

   [If no, then no further questions.]

9. Is Kalydeco being prescribed by, or in consultation with, a pulmonologist? Y N

   [If no, then no further questions.]

10. Will Kalydeco be used in combination with strong CYP3A inducers such as rifampin, rifabutin, phenobarbital, carbamazepine, phenytoin, or St. John's wort? Y N

    [If yes, then no further questions.]

11. Will the patient be on other cystic fibrosis agents to manage and control symptoms (i.e., dornase alpha, tobramycin, hypertonic saline, or Cayston)? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date