Iowa Department of Human Services

**Request for Prior Authorization**
**IVACAFTOR (KALYDECO™)**

**FAX Completed Form To**
1 (800) 574-2515

**Provider Help Desk**
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

| IA Medicaid Member ID # | Patient name | DOB |
|---|---|---|
| Patient address | | |
| Provider NPI | Prescriber name | Phone |
| Prescriber address | | Fax |
| Pharmacy name | Address | Phone |

**Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.**

| Pharmacy NPI | Pharmacy fax | NDC |
|---|---|---|

**Prior authorization is required for Kalydeco™ (ivacaftor). Payment will be considered for patients when the following criteria are met: 1) Patient meets the FDA approved age; and 2) Patient has a diagnosis of cystic fibrosis; and 3) Patient has one of the CFTR gene mutations as indicated in the FDA approved label as detected by an FDA-cleared CF mutation test; and 4) Prescriber is a CF specialist or pulmonologist; and 5) Baseline liver function tests (AST/ALT) are provided. If the criteria for coverage are met, an initial authorization will be given for 3 months. Additional approvals will be granted for 6 months at a time if the following criteria are met: 1) Adherence to ivacaftor therapy is confirmed; and 2) Liver function tests (AST/ALT) are assessed every 3 months during the first year of treatment and annually thereafter.**

☐ **Kalydeco™**

| Strength | Dosage Instructions | Quantity | Days Supply |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

**Diagnosis (Attach copy of FDA-cleared CF mutation test results):** _____

**Attach copy of baseline liver function test (AST/ALT).**

**Prescriber Specialty:** ❑ CF Specialist ❑ Pulmonologist ❑ Other (specify): _____

**Renewal Requests:**

**Patient is adherent to ivacaftor therapy:** ☐ Yes ☐ No

**Liver function tests (AST/ALT) are assessed every 3 months during first year of treatment and annually thereafter:** ☐ Yes ☐ No Most recent lab date: _____

**Ivacaftor Therapy Start Date:** _____

***Attach lab results and other documentation as necessary.***

| Prescriber signature (Must match prescriber listed above.) | Date of submission |
|---|---|

***IMPORTANT NOTE:*** *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*