US Family Health Plan
Prior Authorization Request Form for
ivacaftor **(Kalydeco)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is Kalydeco being used for the treatment of cystic fibrosis (CF) in a patient age 12 months or older?	☐ Yes Proceed to Question 2	☐ No **STOP** **Coverage not approved**
2. Is the patient homozygous for the F508del mutation in the CFTR gene?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to Question 3
3. Does the patient have a specific CF-related gene mutation that has been detected by an FDA-approved test?	☐ Yes Proceed to Question 4	☐ No **STOP** **Coverage not approved**
4. What is the gene mutation? *Prescriber please document the gene mutation:* _____	**Sign and date below**	

***CFTR** = cystic fibrosis transmembrane conductance regulator*

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[14 December 2018]