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 855-273-5735

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)?	☐ Yes Proceed to Question **2**	☐ No **STOP** **Coverage not approved**
2. Is the patient's age appropriate according to the FDA approved indication of Kalydeco?	☐ Yes Proceed to Question **3**	☐ No **STOP** **Coverage not approved**
3. Is the requested medication prescribed by or in consultation with a pulmonologist?	☐ Yes Proceed to Question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient have one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to Kalydeco potentiation based on clinical and/or in vitro assay data?	☐ Yes Proceed to Question **5**	☐ No **STOP** **Coverage not approved**
5. Is the genotype known or unknown?	☐ Known - Proceed to Question **7** ☐ Unknown - Proceed to Question **6**	
6. Has an FDA-approved test been used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use?	☐ Yes Proceed to Question **7**	☐ No **STOP** **Coverage not approved**
7. Will Kalydeco be used concomitantly with Orkambi, Symdeko, or Trikafta?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

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

_____ Prescriber Signature

_____ Date

[09 June 2021]