AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization

Kalydeco™ (ivacaftor)

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
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 is 2 years of age or older; and 2) Has a diagnosis of cystic fibrosis with one of the following mutations in the CFTR gene: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, S549R, and R117H as detected by an FDA-cleared CF mutation test; and 3) Prescriber is a CF specialist or pulmonologist; and 4) Baseline liver function tests (AST/ALT) and FEV_1, if age appropriate, are provided; and 5) Patient does not have one of the following infections documented on the most recent sputum culture: *Burkholderia cenocepacia, Burkholderia dolosa, Mycobaterium abscessus*. 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) Response to therapy is documented by prescriber (e.g., improved FEV_1 from baseline, decreased exacerbations, improved quality of life) or rationale for continued care; and 3) Liver function tests (AST/ALT) are assessed every 3 months during the first year of treatment and annually thereafter.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

☐ **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) and FEV_1 or indicate why not appropriate:

Prescriber Specialty: ☐ CF Specialist ☐ Pulmonologist ☐ Other (specify):

Most recent sputum culture negative for *Burkholderia cenocepacia, Burkholderia dolosa, Mycobaterium abcessus:*

Date: (please attach copy of results)

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Renewal Requests:

Patient is adherent to ivacaftor therapy: ☐ Yes ☐ No

Document response to therapy (improved FEV_1 from baseline, weight increased from baseline, decreased exacerbations, improved quality of life) or rationale for continued care. Please provide labs, if applicable, and specific documentation of improvement:

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.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
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.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.