BlueCross BlueShield Federal Employee Program

KALYDECO
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Kalydeco (ivacaflor)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

How many units will the patient need for an 84-day supply? _____ unit(s) per 84 days

1. What is the patient's diagnosis?
   ❑Cystic Fibrosis (CF)
   ❑Other diagnosis ***(please specify)*:** _____
2. Will the patient be taking another *cystic fibrosis transmembrane conductance regulator (CFTR) potentiator? ❑Yes* ❑No
   If YES, specify the medication: _____
   CFTR Potentiators: Orkambi (ivacaftor/lumacaftor), Symdeko (ivacaftor/tezacaftor), Trikafta (ivacaftor/tezacaftor/elexacftor)
3. Has the patient been on Kalydeco continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
   a. Does the patient have a *CFTR gene mutation responsive to Kalydeco? ❑Yes ❑No
   See Page 2 for a list of CFTR Gene Mutations that are Responsive to Kalydeco
   b. Is the patient homozygous for the *F508del* mutation in the CFTR gene? ❑Yes ❑No
   c. **Age 6 or Older:** What is the pretreatment percent predicted forced expiratory volume (ppFEV1)? _____
   d. Will the patient's ALT and AST levels be obtained prior to initiating Kalydeco? ❑Yes* ❑No
   If YES, does the prescriber agree to monitor the patient's ALT and AST levels every three months during the first year of treatment and annually thereafter? ❑Yes ❑No
   e. What is the prescribing physician's specialty? ***Please select answer below:***
   ❑Gastroenterologist ❑Pulmonologist ❑Other specialty ***(please specify):*** _____
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
   a. **Age 5 or Younger:** Has the patient's symptoms improved or stabilized from baseline? ❑Yes ❑No
   b. **Age 6 or Older:** Has the patient been stable or has there been an improvement of ppFEV$_1$ from baseline? ❑Yes* ❑No
   c. Does the prescriber agree to monitor the patient's ALT and AST levels annually? ❑Yes ❑No

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CFTR Gene Mutations that are Responsive to Kalydeco

*711+3A→G **	*D924N*	*G178E*	*H1375P*	*M952I*	*R117P*	*S549N **	*V562I*
*2789+5G→A **	*D1152H **	*G178R **	*I148T*	*M952T*	*R170H*	*S549R **	*V754M*
*3272-26A→G **	*D1270N*	*G194R*	*I175V*	*P67L **	*R347H **	*S589N*	*V1293G*
*3849+10kbC→T **	*E56K*	*G314E*	*I807M*	*Q237E*	*R347L*	*S737F*	*W1282R*
A120T	*E193K*	*G551D **	*I1027T*	*Q237H*	*R352Q **	*S945L*	*Y1014C*
A234D	*E822K*	*G551S **	*I1139V*	*Q359R*	*R553Q*	*S977F **	*Y1032C*
A349V	*E831X **	*G576A*	*K1060T*	*Q1291R*	*R668C*	*S1159F*	
*A455E **	*F311del*	*G970D*	*L206W **	*R74W*	*R792G*	*S1159P*	
A1067T	*F311L*	*G1069R*	*L320V*	*R75Q*	*R933G*	*S1251N **	
D110E	*F508C*	*G1244E **	*L967S*	*R117C **	*R1070Q*	*S1255P **	
D110H	*F508C;S1251N †*	*G1249R*	*L997F*	*R117G*	*R1070W **	*T338I*	
D192G	*F1052V*	*G1349D **	*L1480P*	*R117H **	*R1162L*	*T1053I*	
*D579G **	*F1074L*	*H939R*	*M152V*	*R117L*	*R1283M*	*V232D*	

*** Clinical data exist for these mutations.**
† Complex/compound mutations where a single allele of the CFTR gene has multiple mutations; these exist independent of the presence of mutations on the other allele.

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***