Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Kalydeco (Ivacaftor) (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Kalydeco (Ivacaftor) (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)	
KALYDECO 150MG TABLET	KALYDECO 25MG GRANULES PACKET
KALYDECO 50MG GRANULES PACKET	KALYDECO 75MG GRANULES PACKET

Patient Information	
Patient Name:	
Patient ID:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:
Directions for administration:	

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   If the answer to this question is yes, approved for 365 days.
   If the answer to this question is no, go to question 2.

2. Is the patient greater than or equal to 4 months of age? Y N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, denied.

3. Does the patient have a claim for a CYP3A4 inducer in the last 45 days? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 4.

4. Does the patient have a claim for a strong CYP3A4 inhibitor in the last 45 days? Y N
   If the answer to this question is yes, go to question 6.
   If the answer to this question is no, go to question 5.

5. Does the patient have a claim for a moderate CYP3A4 inhibitor in the last 45 days? Y N
   If the answer to this question is yes, go to question 7.
   If the answer to this question is no, go to question 8.

6. Is the requested quantity greater than nine tablets or packets per claim (2 units per week)? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 9.

7. Is the requested quantity greater than one tablet or packet per day? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 9.

8. Is the requested quantity greater than two tablets or packets per day? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 9.

9. Will the patient have concurrent therapy with Orkambi, Symdeko, and/or Trikafta? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 10.

10. Does the patient have a diagnosis of cystic fibrosis with one mutation in the CFTR gene that is responsive to ivacaftor based on clinical and/or in vitro assay data? If the genotype is unknown, an FDA-cleared cystic fibrosis mutation test should be used to detect the presence of a CFTR mutation. Y N
    If the answer to this question is yes, go to question 11.
    If the answer to this question is no, denied.

11. Is this request for a non-preferred drug? Y N
    If the answer to this question is yes, go to question 12.
    If the answer to this question is no, approved for 365 days.

12. Has the patient failed a treatment trial with at least 1 preferred agent? Y N
    If the answer to this question is yes, approved for 365 days.
    If the answer to this question is no, go to question 13.

13. Is there a documented allergy or contraindication to preferred agents in this class? Y N
    If the answer to this question is yes, approved for 365 days.
    If the answer to this question is no, go to question 14.

14. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
    If the answer to this question is yes, approved for 365 days.
    If the answer to this question is no, denied.

Comments:

I affirm that the information given on this form is true and accurate as of this date.

_____ _____

Prescriber (or Authorized) Signature Date