OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Kalydeco® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength: / Dosage Form:
❑ Check if requesting **brand**	Directions for Use:
❑ Check if request is for **continuation of therapy**	

Clinical Information (required)

Select the diagnosis below:

❑ Cystic fibrosis
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Select if the patient has the following mutations on at least one allele in the cystic fibrosis transmembrane conductance regulator gene as detected by an FDA cleared cystic fibrosis mutation test or at a Clinical Laboratory Improvement Amendments (CLIA)-approved facility:*

❑ A455E	❑ D1152H	❑ F1052V	❑ G1069R	❑ P67L	❑ R352Q	❑ S945L	❑ 2789+5G → A
❑ A1067T	❑ D1270N	❑ F1074L	❑ G1244E	❑ R74W	❑ R1070Q	❑ S977F	❑ 3272–26A → G
❑ D110E	❑ E56K	❑ G178R	❑ G1349D	❑ R117C	❑ R1070W	❑ S1251N	❑ 3849+10kbC → T
❑ D110H	❑ E193K	❑ G551D	❑ K1060T	❑ R117H	❑ S549N	❑ S1255P	
❑ D579G	❑ E831X	❑ G551S	❑ L206W	❑ R347H	❑ S549R	❑ 711+3A → G	

**Please note: Chart documentation of the above is required to be submitted along with this fax.*

Is Kalydeco prescribed by or in consultation with a pulmonologist or specialist affiliated with a CF care center? ❑ **Yes** ❑ **No**

Reauthorization:
If this is a reauthorization request, answer the following question:

Is there documentation the patient is benefiting from Kalydeco treatment (i.e., improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations, or stable lung function)? ❑ **Yes** ❑ **No**

Is Kalydeco prescribed by or in consultation with a pulmonologist or specialist affiliated with a CF care center? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading-dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____
❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.