Print Reset

AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

DUR MEDICATION KALYDECO® (IVACAFTOR) & ORKAMBI™ (LUMACAFTOR/IVACAFTOR)

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

KALYDECO® (ivacaftor) – to receive a ONE (1) year approval for this drug, complete the following questions:

1. Does the member have a diagnosis of cystic fibrosis (CF)?
   ☐ Yes ☐ No
2. Does the member have one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor detected by an FDA cleared test? *(Documentation required – include a copy of the test results with this fax)*
   ☐ Yes ☐ No
3. Is the member 1 month of age or older?
   ☐ Yes ☐ No
4. Has baseline ALT and AST testing been done?
   ☐ Yes ☐ No
   (Documentation required – include a copy of the test results with this fax)

ORKAMBI™ (lumacaftor/ivacaftor) – to receive a one (1) year approval for this drug, complete these questions:

1. Does the member have a diagnosis of cystic fibrosis (CF)?
   ☐ Yes ☐ No
2. Does the member have a homozygous F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene detected by a FDA cleared test?
   ☐ Yes ☐ No
   (Documentation required – include a copy of the test results with this fax)
3. Is the member 1 year of age or older?
   ☐ Yes ☐ No
4. Has baseline ALT, AST, and bilirubin testing been done?
   ☐ Yes ☐ No
5. Has baseline ophthalmic examination been performed?
   ☐ Yes ☐ No
6. For renewal, liver function testing (LFT) documentation is required.

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by patient records.

Please include ALL requested information; Incomplete forms will delay the PA process.
Submission of documentation does NOT guarantee coverage.