



NC DMA Pharmacy Request for Prior Approval - Kalydeco



Recipient Information

DMA-3484 (V.01)

1. Recipient Last Name: _____ 2. First Name: _____
 3. Recipient ID #: _____ 4. Recipient Date of Birth: _____ 5. Recipient Gender: _____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: Health Choice:

Prescriber Information

7. Prescribing Provider #: _____ NPI: or Atypical:

8. Prescriber DEA #: _____

Requester Contact Information

Name: _____ Phone #: _____ Ext: _____

Drug Information

9. Drug Name: **Kalydeco** 10. Strength: _____ 11. Quantity Per 30 Days: _____
 12. Length of Therapy (in days): up to 30 60 90 120 180 365 Other: _____

Clinical Information

1. Does the beneficiary have a diagnosis of Cystic Fibrosis? Yes No
 2. Is the beneficiary age 6 or greater? Yes No
 3. Does the beneficiary have a documented G551D mutation in the CFTR gene? Yes No
 (Documentation must accompany this prior approval request)
 4. Is the total daily dose prescribed 300mg/day total or less? Yes No
 5. Did the beneficiary have a baseline ALT and AST assessed prior to beginning therapy? Yes No
 Please list ALT and AST results and date labs were done.

Signature of Prescriber: _____ Date: _____

*Prescriber signature mandatory

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSC at: (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505