Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Kalydeco - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the prescriber a pulmonologist, endocrinologist, or pediatrician?

☐ Yes ☐ No

Q2. Does the patient have a confirmed diagnosis of cystic fibrosis?

☐ Yes ☐ No

Q3. Is the patient 4 months of age or older (please note oral granules are indicated for patients 4 months to less than 6 years of age; oral tablets are indicated for patients 6 years of age and older)?

☐ Yes ☐ No

Q4. Has appropriate genetic testing been conducted? Appropriate lab work must be attached.

☐ Yes ☐ No

Q5. Has baseline liver function (including alanine aminotransferase [ALT] and aspartate aminotransferase [AST]) been assessed prior to initiation of treatment? Labs must be attached.

☐ Yes ☐ No

Q6. Additional Information:

☐ Yes ☐ No

Q7. Requested Duration:

☐ 12 months

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Patient Name:	**Prescriber Name:**

Prescriber Signature

Date

2022 Medicare Prior Authorization Request