Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Ivacaftor (Kalydeco) – Medical Necessity Request

1. What is the diagnosis?
   - □ Cystic Fibrosis
     a. What is the member's confirmed mutation?
        - □ G551D
        - □ Other: _____

   - □ Other: _____

Physician office's signature*_____ Print Name_____

*** Form must be completed and signed by physician or licensed representative from the physician's office**