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Tezacaftor/Ivacaftor (Symdeko™)
Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004
Provider Help Desk 1-800-454-3730

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	**Specify:** _____

7. Diagnosis: _____

8. Approval criteria: Check all boxes that apply
Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.

Prior authorization is required for Symdeco™ (tezacaftor/ivacaftor). Payment will be considered for patients when the following criteria are met: 1) Patient meets the FDA approved age; and 2) Patient has a diagnosis of cystic fibrosis (CF); and 3) Patient is homozygous for the F580del mutation or patient has at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor (listed in the FDA approved labeling) based on in vitro data and/or clinical evidence; and 4) Prescriber is a CF specialist or pulmonologist; and 5) Baseline liver function tests (AST/ALT) are provided. If the criteria for coverage are met, an initial authorization will be given for 6 months. Additional approvals will be granted if the following criteria are met: 1) Adherence to tezacaftor/ivacaftor therapy is confirmed; and 2) Liver function tests (AST/ALT) are assessed every 3 months during the first year of treatment and annually thereafter.

Attach copy of baseline liver function test (AST/ALT).

Prescriber specialty: ☐ **CF Specialist** ☐ **Pulmonologist** ☐ **Other (specify)**:_____

Renewal requests:
Patient is adherent to tezacaftor/ivacaftor therapy: ☐ **Yes** ☐ **No**

Liver function tests (AST/ALT) are assessed every 3 months during first year of treatment and

annually thereafter: ☐ **Yes** ☐ No Most recent lab date:_____

Tezacaftor/Ivacaftor therapy start date:

_____

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.