





## 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 informa          | 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 baselir   | ne liver function test (AST/AL | Т).                           |                          |  |
| Prescriber specialty:   CF Specialist   Pulmonologist   Other (specify):   |                                |                               |                          |  |
| Renewal requests:  Patient is adherent to tezacaftor/ivacaftor therapy:   Yes  No  |                                |                               |                          |  |
| Liver function tests (A  | ST/ALT) are assessed every 3   | months during first year of t | reatment 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                  |  |  |
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| 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. |                       |  |  |

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