FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Symdeko™ Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Cystic fibrosis

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is the patient homozygous for the F508del mutation as detected by a FDA-cleared cystic fibrosis mutation test or Clinical Laboratory Improvement Amendments (CLIA)-approved facility? ❑ **Yes** ❑ **No**

Select if the patient has one of the following mutations on at least one allele in the CF transmembrane conductance regulator (CFTR) gene as detected by FDA-cleared cystic fibrosis mutation test or Clinical Laboratory Improvement Amendments (CLIA)-approved facility:

❑ E56K	❑ E193K	❑ 711+3A → G	❑ A1067T	❑ 3272-26A → G
❑ P67L	❑ L206W	❑ E831X	❑ R1070W	❑ 3849 + 10kbC → T
❑ R74W	❑ R347H	❑ S945L	❑ F1074L	
❑ D110E	❑ R352Q	❑ S977F	❑ D1152H	
❑ D110H	❑ A455E	❑ F1052V	❑ D1270N	
❑ R117C	❑ D579G	❑ K1060T	❑ 2789+5G → A	

Is Symdeko prescribed by or in consultation with a pulmonologist or specialist affiliated with a CF care center? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had a positive clinical response to Symdeko (tezacaftor/ivacaftor) therapy (e.g., improvement in lung function or decreased number of pulmonary exacerbations)? ❑ **Yes** ❑ **No**

Quantity Limit Requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes

❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.