



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: |
| <input type="checkbox"/> Check if generic substitution is acceptable | | Directions for Use: | |
| <input type="checkbox"/> Check if request is for continuation of therapy | | | |

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:

| | | | | |
|--------------------------------|--------------------------------|-------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> E56K | <input type="checkbox"/> E193K | <input type="checkbox"/> 711+3A → G | <input type="checkbox"/> A1067T | <input type="checkbox"/> 3272-26A → G |
| <input type="checkbox"/> P67L | <input type="checkbox"/> L206W | <input type="checkbox"/> E831X | <input type="checkbox"/> R1070W | <input type="checkbox"/> 3849 + 10kbC → T |
| <input type="checkbox"/> R74W | <input type="checkbox"/> R347H | <input type="checkbox"/> S945L | <input type="checkbox"/> F1074L | |
| <input type="checkbox"/> D110E | <input type="checkbox"/> R352Q | <input type="checkbox"/> S977F | <input type="checkbox"/> D1152H | |
| <input type="checkbox"/> D110H | <input type="checkbox"/> A455E | <input type="checkbox"/> F1052V | <input type="checkbox"/> D1270N | |
| <input type="checkbox"/> R117C | <input type="checkbox"/> D579G | <input type="checkbox"/> K1060T | <input type="checkbox"/> 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.

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