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	Directions for Use:	
❑ 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 Symdeko prescribed by a pulmonologist? ❑ **Yes** ❑ **No**

Is there documentation that the patient is homozygous for the F508del mutation? ❑ **Yes** ❑ **No**

Select if the patient has the following Symdeko responsive mutation in the CFTR gene:*

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

**Please note: If the patient's genotype is unknown, an FDA-cleared test must be used to detect the presence of CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test.*

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.