SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Symdeko® (tezacaftor/ivacaftor)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Recommended dose: 1 tablet (tezacaftor 100mg/ivacaftor 150mg) in the morning and 1 tablet (ivacaftor 150mg in the evening **(approximately 12 hours apart)**.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Authorization Approval Length: ONE (1) Year

1. Does member have a diagnosis of Cystic Fibrosis? ❑ **Yes** ❑ **No**

AND

(Continued on next page)

2. Is member **6** years or older? ❑ **Yes** ❑ **No**

AND

3. Is member homozygous for the **F508del** mutation in the CFTR gene as confirmed by an FDA-cleared CF mutation test? **(Document required; include a copy of the test with this request)**
❑ **Yes** ❑ **No**

OR

4. Does member have **one (1)** of the following mutations in the CFTR gene as confirmed by an FDA-cleared CF mutation test: E56K, P67L, R74W, D110E, D110H, R117C, E193K, L206W, R347H, R352Q, A455E, D579G, 711+3A➔G, 3272-26A➔G, or 3849+10kbc➔T? **(Document required; include a copy of the test with this request)** ❑ **Yes** ❑ **No**

AND

5. Has baseline ALT and AST testing been done? **(Documentation required; include a copy of the test with this request)** ❑ **Yes** ❑ **No**

For Reauthorization approval - liver function testing (LFT) documentation is required

Medication being provided by a Specialty Pharmacy - PropriumRx

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: 4/19/2018
REVISED/UPDATED/REFORMATTED: ~~6/21/2018~~; ~~8/30/2018~~; ~~4/12/2019~~; ~~9/7/2019~~ **11/9/2023**