Symdeko (tezacaftor/ivacaftor)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Cystic fibrosis ☐ Other diagnosis: _____ICD-10 Code(s): _____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Is this request for initial therapy (meaning the patient has not received therapy with Symdeko in the past AND there are no paid claims for Symdeko in member's history)? ☐ Yes ☐ No
If No, please complete "Renewal Therapy" section below.

Does patient have homozygous F508del mutation? ☐ Yes ☐ No *Test documentation must be provided*

Does the patient have a cystic fibrosis transmembrane conductance regulator (CFTR) gene mutation listed within the current FDA prescribing information? ☐ Yes ☐ No *Test documentation must be provided*

Is documentation available showing this patient's most recent (baseline) measurements for FEV1 and FEV1 percentage of predicted, obtained within the past 30 days while the patient is NOT receiving treatment with Kalydeco? ☐ Yes ☐ No *Please submit this documentation, e.g., chart notes*

Will the patient be concurrently using a daily oral inhaled corticosteroid and a daily bronchodilator? ☐ Yes ☐ No

Has the patient used Pulmozyme within the past year? ☐ Yes ☐ No

<u>Renewal Therapy</u>
You must answer ALL of the following questions.

Is this request for initial therapy (meaning the patient has not received therapy with Symdeko in the past AND there are no paid claims for Symdeko in member's history)? ☐ Yes ☐ No
If Yes, please complete "Initial Therapy" section above.

Is this request for renewal of therapy (meaning the patient is currently receiving therapy with Symdeko AND paid claims are in member's history)? ☐ Yes ☐ No
Note: use of samples only and/or access through patient assistance program only does not qualify as current therapy subject to renewal; those should be submitted as initial therapy instead.

If No, please complete "Initial Therapy" section above.

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Is documentation available which shows the patient's current FEV1 measurements? □ **Yes** □ **No**

Current FEV1 measurements are defined as the most recent FEV1 and FEV1 percentage of predicted that were measured within the previous 30 days while the patient is receiving treatment with Symdeko.
Please submit this documentation, such as chart notes.

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: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811