



**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](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:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

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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:
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2. LIST DIAGNOSES: **ICD-10:**

<input type="checkbox"/> Cystic fibrosis <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
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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

Renewal Therapy

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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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:** _____

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909

