OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(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. **Incomplete form will delay authorization process.**

Drug Requested: Symdeko® (tezacaftor/ivacaftor)

DRUG INFORMATION: Complete all information below or authorization process will be delayed.

Drug Form/Strength: _____

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

Diagnosis: _____ ICD Code, if applicable: _____

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

Authorization approval – 1 year

CLINICAL CRITERIA: **ALL** boxes below **MUST** be checked to qualify. Lab results and chart notes **MUST** be attached to ensure authorization will **NOT** be delayed**.**

1. Is the member 12 ≥ years of age? ❑ Yes ❑ No

AND

2. Does the member have a diagnosis of Cystic Fibrosis. ❑ 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 **(see chart below)** in the CFTR gene as confirmed by an FDA-cleared CF mutation Test? **(Lab documentation required; include a copy of the test with this request)** ❑ Yes ❑ No

***CFTR Mutations Responsive to Symdeko:**

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

(continued on next page)

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

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

Medication being provided by a Specialty Pharmacy
Sentara Norfolk General CM Pharmacy

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.*

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name**:** _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: 4/19/2018
REVISED/UPDATED ~~6/21/2018;~~ **8/30/2018**