

# OPTIMA HEALTH COMMUNITY CARE

## 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 1-800-319-5003. 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 or authorization process will 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	

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

(continued on next page)

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

***Medication being provided by a Specialty Pharmacy (check applicable box below):***

**For Optima Commercial Members:**

PropriumRx

**For Optima Family Care Members:**

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