OPTIMA HEALTH PLAN

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) **RE-AUTHORIZATION FORM**

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:*** _____

- ***Number of hospitalization (ICD 277-00-277.09) will be defined by ICD.***
- ***Symdeko® will NOT be covered for patients with FEV_1 > 90 % initiation.***

CLINICAL CRITERIA: Check applicable boxes below. To qualify, ALL boxes MUST be checked or authorization process will be delayed. All documentation/progress notes and/or lab results MUST be attached and MUST be compliant.

- ***Re-Approval will be based on all THREE (3) of the following:***
  - ❑ Has member's Body weight increased at least 1.5kg? ❑ Yes ❑ No
  - ❑ Has the FEV1 ≥ 5%? ❑ Yes ❑ No
  - ❑ Has hospitalization decreased since prior to Symdeko® therapy? ❑ Yes ❑ No
  - ❑ Sent Lab results documenting the following ***(must be attached)***:
    - ❑ Recent LFTs (within the last month)
    - ❑ Patient does not have positive cultures for Burkholderina cencopacia, Burkholderia dolosa, or Mycobacterium abscessus. ***Lab documentation required within last six (6) months of THIS request.***
    - ❑ ***Follow up ophthalmic examination***
  - ❑ ***Member is currently COMPLIANT on at least TWO (2) of the following:***
    - ❑ Dornase alfa
    - ❑ Hypertonic saline
    - ❑ Inhaled or oral antibiotics within the last 3 months

Baseline Date ***(PRIOR to Symdeko®)***: _____	Re-Authorization Date: _____
FEV1 Baseline (***last FEV1 prior to Symdeko®)***: _____	FEV1 Reauthorization ***(FEV1 AFTER last dose of Symdeko®):*** _____
Baseline Weight: _____	Re-Authorization Weight: _____
BMI baseline: _____	BMI Re-authorization Weight: _____
Please note the number of hospitalizations while on Symdeko® will be evaluated: _____	
While on Symdeko®, has IV/po antibiotics changed > 3 times? ❑ Yes ❑ No	

(continued on next page)

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: 6/20/2018