Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Symdeko® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Cystic fibrosis (CF)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is the patient homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene? ❑ **Yes** ❑ **No**

Lab documentation must be submitted

Select if the patient has one of the following mutations in the CFTR gene that is responsive to Symdeko based on in vitro data and/or clinical evidence:

Lab documentation must be submitted

❑ A1067T	❑ E193K	❑ L206W	❑ S945L
❑ A455E	❑ E56K	❑ P67L	❑ S977F
❑ D110E	❑ E831X	❑ R1070W	❑ 711+3A ->G
❑ D110H	❑ F1052V	❑ R117C	❑ 2789+5G ->A
❑ D1152H	❑ F1074L	❑ R347H	❑ 3272-26A ->G
❑ D1270N	❑ F508del	❑ R352Q	❑ 3849+10kbC ->T
❑ D579G	❑ K1060T	❑ R74W	

Select the following that applies to the patient:

- ❑ Baseline FEV1 within the last 30 days is ≤ 90% (*Lab documentation must be submitted)*
- ❑ Baseline eGFR or SCr within the last 3 months (*Lab documentation must be submitted)*
- ❑ Baseline LFTs prior to initiating therapy, then every 3 months the first year, then annually (*Lab documentation must be submitted)*
- ❑ Documentation of the number of pulmonary exacerbations in preceding 6 months
- ❑ Documentation of baseline body mass index
- ❑ Documentation of baseline ophthalmic examination to monitor lens opacities/cataracts (*Lab documentation must be submitted)*
- ❑ Patient does not have positive cultures for *Burkholderia cenocepacia*, *Burkholderia dolosa*, or *Mycobacterium abscessus* (*Lab documentation within last six (6) months of THIS request must be submitted)*

Select if the patient is currently COMPLIANT on the following:

- ❑ CFTR modulator therapy [Orkambi (lumacaftor/ivacaftor)] (Must be compliant on Orkambi if switching to Symdeko)
- ❑ Dornase alfa
- ❑ Hypertonic saline
- ❑ Inhaled or oral antibiotics within the last three months

Symdeko® Prior Authorization Request Form (Page 2 of 2)

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Reauthorization:

If this is a reauthorization request, answer the following questions:

Select the following that applies to the patient:

- ❑ FEV1 ≥ 5%
- ❑ Hospitalization decreased since prior to Symdeko therapy
- ❑ Patient's body weight increased at least 1.5kg

Select the following the patient has lab results documenting:

Lab documentation must be submitted

- ❑ Follow up ophthalmic examination
- ❑ Patient does not have positive cultures for *Burkholderia cenocepacia, Burkholderia dolosa*, or *Mycobacterium abscessus* *(Lab documentation within last six (6) months of THIS request must be submitted)*
- ❑ Recent LFTs (within the last month)

Select if the patient is currently COMPLIANT on the following:

- ❑ Dornase alfa
- ❑ Hypertonic saline
- ❑ Inhaled or oral antibiotics within the last three months

Chart notes and any lab results MUST be submitted with this request
****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.

Prescriber Signature: _____ **Date:** _____

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: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.