pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

SYMDEKO (tezacaftor/ivacaftor) PRIOR AUTHORIZATION FORM

For **Symdeko** and **Quantity Limits/Daily Dose Limits** prior authorization guidelines, see http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested: Symdeko	Dosage form: ☐tablet ☐other: _____	Strength:	
Directions:		Qty:	Refills:
Diagnosis:		Dx code (required):	

Specialty Pharmacy Drug Program: Symdeko is part of the DHS Specialty Pharmacy Drug Program and is only available from one of the two DHS specialty pharmacies – **Walgreen's Specialty Pharmacy.**

Is the medication being prescribed by, or in consultation with, a pulmonologist or cystic fibrosis specialist? ☐Yes ☐No

Initial requests	
1. Does the beneficiary have results of an FDA-cleared cystic fibrosis (CF) mutation test that shows the presence of a mutation(s) in the CFTR gene as noted in the package labeling?	☐Yes – *Submit documentation of results.* ☐No
2. Does the beneficiary have documentation of a baseline (pre-treatment) FEV_1?	☐Yes – *Submit documentation of results.* ☐No
3. Does the beneficiary have lab results of baseline (pre-treatment) ALT and AST (liver function tests/LFTs)?	☐Yes – *Submit documentation of results.* ☐No
4. Will the beneficiary have repeat liver function tests (ALT, AST, bilirubin) every 3 months during the first year of treatment and annually thereafter?	☐Yes – *Submit chart documentation.* ☐No
5. Does the beneficiary have liver disease or liver impairment?	☐Yes ☐No *Submit documentation of degree of impairment.*
6. Is the beneficiary taking any of the following medications? Check all that apply. ☐strong P450 3A inducer (e.g., carbamazepine, phenobarbital, phenytoin, rifampin, etc.) ☐moderate or strong P450 3A inhibitor (e.g., azole antifungal, macrolide antibiotic, ritonavir, etc.)	☐Yes ☐No *Submit beneficiary's complete current medication list.*
Renewal requests	
1. Does the beneficiary have recent lab results of liver function tests (ALT, AST, bilirubin)? *Note: Testing should be completed every 3 months for the first year of therapy and annually thereafter.*	☐Yes – *Submit documentation of results.* ☐No
2. Does the beneficiary have liver disease or liver impairment?	☐Yes ☐No *Submit documentation of degree of impairment.*
3. Is the beneficiary receiving clinical benefit from Symdeko?	☐Yes ☐No *Submit documentation of beneficiary's clinical response.*
4. Is the beneficiary taking any of the following medications? Check all that apply. ☐strong P450 3A inducer (e.g., carbamazepine, phenobarbital, phenytoin, rifampin, etc.) ☐moderate or strong P450 3A inhibitor (e.g., azole antifungal, macrolide antibiotic, ritonavir, etc.)	☐Yes ☐No *Submit beneficiary's complete current medication list.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date:**

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