Prior Authorization Request Form for
tezacaftor - ivacaftor **(Symdeko)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is Symdeko being prescribed for the treatment of cystic fibrosis?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is this agent being used in combination therapy with Orkambi or Kalydeco?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **3**
3. Is this drug being requested for an FDA approved age?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the patient homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene as detected by an FDA-approved CF mutation test?	☐ Yes Proceed to question **6**	☐ No Proceed to question **5**
5. Does the patient have at least one specific gene mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to Symdeko as detected by an FDA-approved CF mutation test?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Please provide the CF-related gene mutation. _____	**Sign and date below**	

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[5 July 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: