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

JOHNS HOPKINS
HEALTH PLANS
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

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 drug being requested for an FDA approved age?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the requested medication prescribed by or in consultation with a pulmonologist?	☐ 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?	☐ Yes Proceed to question **6**	☐ No Proceed to question **5**
5. Does the patient have at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to Symdeko potentiation based on in vitro data and/or clinical evidence?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is the genotype known or unknown?	☐ Known - Proceed to question **8** ☐ Unknown - Proceed to question **7**	

	7. Has an FDA-approved test been used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
	8. Is this agent being used in combination therapy with Orkambi, Kalydeco, or Trikafta?	☐ Yes **STOP** **Coverage not approved**	☐ No **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

[09 June 2021]

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