Iowa Department of Human Services

Request for Prior Authorization Tezacaftor/Ivacaftor (Symdeko™)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for Symdeco™ (tezacaftor/ivacaftor). Payment will be considered for patients when the following criteria are met: 1) Patient meets the FDA approved age; and 2) Patient has a diagnosis of cystic fibrosis (CF); and 3) Patient is homozygous for the F580del mutation or patient has at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor (listed in the FDA approved labeling) based on in vitro data and/or clinical evidence; and 4) Prescriber is a CF specialist or pulmonologist; and 5) Baseline liver function tests (AST/ALT) are provided. If the criteria for coverage are met, an initial authorization will be given for 6 months. Additional approvals will be granted if the following criteria are met: 1) Adherence to tezacaftor/ivacaftor therapy is confirmed; and 2) Liver function tests (AST/ALT) are assessed every 3 months during the first year of treatment and annually thereafter.

☐ **Symdeco™**

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis (Attach copy of FDA-cleared CF mutation test results): _____

Attach copy of baseline liver function test (AST/ALT).

Prescriber specialty: ☐ CF Specialist ☐ Pulmonologist ☐ Other (specify): _____

Renewal requests:

Patient is adherent to tezacaftor/ivacaftor therapy: ☐ Yes ☐ No

Liver function tests (AST/ALT) are assessed every 3 months during first year of treatment and annually thereafter: ☐ Yes ☐ No Most recent lab date: _____

Tezacaftor/Ivacaftor therapy start date: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*