Fax completed form to Navitus at: 855-668-8553
For questions, please call: 877-908-6023

TEXAS MEDICAID

Drug Prior Authorization
Cystic Fibrosis Agents: tezacaftor/ivacaftor (SYMDEKO)

Request Information (required)
This request is: ☐ **Expedited* (Urgent)** ☐ **Standard (Non-Urgent)** *Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

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

Please fill out the following information:

1. Medication Requested (Name):
(Go to #2)

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Required Criteria

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

Clinical Criteria (required)

6. Is the member greater than or equal to (≥) six (6) years of age?

- ◯ Yes
(Go to #7)
- ◯ No (Deny)
(Go to #7)

7. Does the member have a claim for a CYP3A4 inducer in the last 45 days?

Examples of CYP3A4 inducers include: APTIOM, armodafinil (NUVIGIL), ATRIPLA, BANZEL, bexarotene (TARGETIN), bosentan (TRACLEER), carbamazepine (CARBATROL, EPITOL, EQUETRO, TEGRETOL), clobazam (ONFI, SYMPAZAN), dexamethasone, dicloxacillin, efavirenz (SUSTIVA), INTELENCE, LYSODREN, modafinil (PROVIGIL), nevirapine (VIRAMUNE), ORILISSA, ORKAMBI, oxcarbazepine (TRILEPTAL, OXTELLAR), phenobarbital, phenytoin (DILANTIN, PHENYTEK), PRIFTIN, primidone (MYSOLINE), rifabutin (MYCOBUTIN), rifampin (RIFADIN), RIFATER, SYMFI, TAFINLAR, XERMELO, XTANDI, and ZELBORAF.

- ◯ Yes (Deny)
  (Go to #8)
- ◯ No
  (Go to #8)

8. Does the member have a diagnosis of cystic fibrosis in the last 730 days?

- ◯ Yes
  (Go to #9)
- ◯ No (Deny)
  (Go to #9)

9. Will the member have concurrent therapy with KALYDECO, ORKAMBI, or TRIKAFTA?

- ◯ Yes (Deny)
  (Go to #10)
- ◯ No
  (Go to #10)

10. Manual Step - Is the member homozygous for the F508del mutation OR does the member have at least one (1) mutation in the Cystic Fibrosis Transmembrane Conductance Regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor based on *in vitro* data and/or clinical evidence? If the genotype is unknown, a United States Food and Drug Administration (FDA) cleared cystic fibrosis mutation test should be used to detect the presence of a CFTR mutation.

- ◯ Yes (Approve - 365 days)
  (Go to #11)
- ◯ No (Deny)
  (Go to #11)

Additional Information

11. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

**** PLEASE FAX COMPLETED FORM TO: 855-668-8553 ****

If criteria not met, submit chart documentation with form citing complex medical circumstances.
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