TEXAS MEDICAID
Clinical Edit Prior Authorization
tezacaftor/ivacaftor and ivacaftor (SYMDEKO)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: COMPLETE REQUIRED CRITERIA

☐ Indicate Primary Diagnosis: _____ ICD 10 Code: _____

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

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Does the client have a claim for a CYP3A4 inducer in the last 45 days?

   Examples include carbamazepine (CARBATROL, EPITOL, EQUETRO, TEGRETOL), phenobarbital, phenytoin (DILANTIN, PHENYTEK), rifampin (RIFADIN), rifabutin (MYCOBUTIN), and certain HIV treatments (ATRIPLA, nevirapine, SUSTIVA, VIRAMUNE).

   ☐ Yes (Deny) ☐ No (Go to #3)

3. Does the client have a diagnosis of cystic fibrosis in the last 730 days?

   ☐ Yes (Go to #4) ☐ No (Deny)

4. Will the client have concurrent therapy with KALYDECO, ORKAMBI or TRIKAFTA?

   ☐ Yes (Deny) ☐ No (Go to #5)

5. Is the client homozygous for the *F508del* mutation **OR** does the client have at least ONE (1) of the following mutations in the *CFTR* gene? [Manual Step]

- A1067T
- A455E
- D110E
- D110H
- D1152H
- D1270N
- D579G
- E193K
- E56K
- E831X
- F1052V
- F1074L
- K1060T
- L206W
- P67L
- R1070W
- R117C
- R347H
- R352Q
- R74W
- S945L
- S977F
- 711+3A → G
- 2789+5G → A
- 3272-26A → G
- 3849+10kbC → T

☐ Yes (Approve – 365 days) ☐ No (Deny)

STEP 3: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.