carolina complete health

Symdeko Prior Authorization

Beneficiary Information

1. Beneficiary Last Name:_____ 2. First Name: _____
3. Beneficiary ID #:_____ 4. Beneficiary Date of Birth:_____ 5. Beneficiary Gender: _____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Prescriber Information

7. Prescribing Provider NPI #: _____
8. Prescriber DEA #: _____

Requester Contact Information

Name:_____ Phone #:_____ Ext. _____

Drug Information

9. Drug Name: _____ 10. Strength:_____ 11. Quantity Per 30 Days: _____

12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐ Other: _____

Clinical Information

1. Does the beneficiary have a diagnosis of Cystic Fibrosis? ☐ Yes ☐ No
2. Is the beneficiary age 12 or greater? ☐ Yes ☐ No
3. Is the beneficiary documented as homozygous for the F508 del mutation in the CFTR gene or does the beneficiary have one mutation in the CFTR gene that is responsive to tezacaftor/ivacaftor? ☐ Yes ☐ No
4. Is the daily dose less than or equal to one tablet (containing tezacaftor 100 mg/ivacaftor 150 mg) in the morning and one tablet (containing ivacaftor 150 mg) in the evening? ☐ Yes ☐ No
5. Did the beneficiary have a baseline ALT and AST assessed prior to therapy? ☐ Yes ☐ No
6. Please list ALT and AST results and lab dates.

_____

Signature of Prescriber: _____ Date: _____

* Prescriber Signature mandatory

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 877-386-4695 Pharmacy PA Call Center: (833) 585-4309