



Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.  
SYMDEKO (Tezacaftor-Ivacaftor) Prior Authorization (PA)  
Pharmacy Benefits Prior Authorization Help Desk  
Length of Authorizations: Initial- 12 months; Continuation- 12 months

**Instructions:**

This form is used by Kaiser Permanente and/or participating providers for coverage of **SYMDEKO (Tezacaftor-Ivacaftor)** . Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: <http://www.providers.kaiserpermanente.org/mas/formulary.html>

**1 – Patient Information**

Patient Name: \_\_\_\_\_ Kaiser Medical ID#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**2 – Prescriber Information**

Prescriber Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ NPI: \_\_\_\_\_  
Prescriber Address: \_\_\_\_\_  
Prescriber Phone #: \_\_\_\_\_ Prescriber Fax #: \_\_\_\_\_

**3 – Pharmacy Information**

Pharmacy Name: \_\_\_\_\_ Pharmacy NPI: \_\_\_\_\_  
Pharmacy Phone # \_\_\_\_\_ Pharmacy Fax #: \_\_\_\_\_

**4 – Drug Therapy Requested**

Drug 1: Name/Strength/Formulation: \_\_\_\_\_  
Sig: \_\_\_\_\_  
Drug 2: Name/Strength/Formulation: \_\_\_\_\_  
Sig: \_\_\_\_\_

### 5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?  
 Initial therapy                       Continuing therapy, State date: \_\_\_\_\_
2. Indicate the Member’s diagnosis for the requested medication: \_\_\_\_\_
3. Is the member ≥6 years of age? **AND**  
 No  Yes
4. Was the member diagnosis of CF confirmed by a clinician with expertise in providing CF care? **AND**  
 No  Yes
5. At least one F508del mutation in the CFTR gene detected using either an FDA-cleared CF mutation test or testing was completed by a CLIA certified laboratory, **OR**  
 No  Yes
6. One of the following mutations known to be responsive to tezacaftor-ivacaftor, invacaftor in the CFTR gene:

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

No  Yes

**For Continuation of Therapy, Please Respond to Additional Questions Below:**

1. Was there documentation of positive clinical response? **AND**  
 No  Yes
2. Did the specialist follow-up occur in the past 12 months? **AND**  
 AST, ALT, bilirubin and ophthalmic changes (patients up to 17 years) are monitored at least annually  
 No  Yes

### 6 – Prescriber Sign-Off

**Additional Information – Please submit chart notes/medical records for the patient that are applicable to this request. Provide any additional supporting information that should be taken into consideration:**

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**I certify that the information provided is accurate. Supporting documentation is available for State audits.**

**Prescriber Signature:**

**Date:**

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