Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Symdeko (Tezacaftor/Ivacaftor and Ivacaftor) (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Symdeko (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)	
SYMDEKO 100/150-150 MG TABS	SYMDEKO 50/75-75 MG TABS

Patient Information	
Patient Name:	
Patient ID:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:
Directions for administration:	

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   If the answer to this question is yes, approved for 365 days.
   If the answer to this question is no, go to question 2.

2. Is the patient greater than or equal to 6 years of age? Y N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, denied.

3. Does the patient have a claim for a CYP3A4 inducer in the last 45 days? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 4.

4. Does the patient have a diagnosis of cystic fibrosis in the last 730 days? Y N
   If the answer to this question is yes, go to question 5.
   If the answer to this question is no, denied.

5. Will the patient have concurrent therapy with Kalydeco, Orkambi or Trikafta? Y N

If the answer to this question is yes, denied.
If the answer to this question is no, go to question 6.

6. Is the patient homozygous for the F508del mutation OR does the patient have at least one mutation in the CFTR gene that is responsive to tezacaftor/ivacaftor based on in vitro data and/or clinical evidence? If the genotype is unknown, an FDA-cleared cystic fibrosis mutation test should be used to detect the presence of a CFTR mutation. Y N
   If the answer to this question is yes, go to question 7.
   If the answer to this question is no, denied.

7. Is this request for a non-preferred drug? Y N
   If the answer to this question is yes, go to question 8.
   If the answer to this question is no, approved for 365 days.

8. Has the patient failed a treatment trial with at least 1 preferred agent ? Y N
   If the answer to this question is yes, approved for 365 days.
   If the answer to this question is no, go to question 9.

9. Is there a documented allergy or contraindication to preferred agents in this class? Y N
   If the answer to this question is yes, approved 365 days.
   If the answer to this question is no, go to question 10.

10. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
    If the answer to this question is yes, approved 365 days.
    If the answer to this question is no, denied.

Comments:

I affirm that the information given on this form is true and accurate as of this date.

_____ _____

Prescriber (or Authorized) Signature Date