Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Symdeko (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 Aetna Better Health New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Symdeko (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Symdeko (tezacaftor/ivacaftor)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Member information

Member name: _____

Member ID: _____

Member Group No.: _____

Member DOB: _____

Member phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this member (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 7.]

2. Has documentation been submitted to support a response to therapy (symptom improvement and/or stable forced expiratory volume in one second [FEV1])? Y N

   If yes, please document response or submit records: _____

   [If no, then no further questions.]

3. Is this request for a pediatric member? Y N

   [If no, skip to question 5.]

4. Has the member had an eye exam (due to the possible development of cataracts)? Y N

   [If no, then no further questions.]

5. Are the member's transaminases (alanine transaminase [ALT], aspartate transaminase [AST]) monitored? Y N

   [If no, then no further questions.]

6. Will therapy be temporarily discontinued for any of the following: A) the member's AST or ALT levels are greater than 5 times the upper limit of normal, or B) the member's ALT or AST are greater than 3 times the upper limit of normal with bilirubin greater than 2 times the upper limit of normal? Y N

   [No further questions.]

7. Does the member have a diagnosis of cystic fibrosis? Y N

   [If no, then no further questions.]

8. Is the member homozygous for the F508 del mutation in the Cystic Fibrosis Transmembrane Regulator (CFTR) gene? Y N

   Note: Laboratory documentation must be submitted.

   [If yes, skip to question 10.]

9. Does the member have at least one of the following mutations in the Cystic Fibrosis Transmembrane Regulator (CFTR) gene that is responsive to Symdeko (tezacaftor/ivacaftor): A1067T, A455E, D110E, D110H, D1152H D1270N, D579G, E193K,E56K, E831X, F1052V, F1074L, K1060T, L206W, P67L, R1070W, R117C, R347H, R352Q, R74W, S945L, S977F, 3272-26A—G, 3849+10kbC—T, 711+3A—G, 2789+5G—A (or other mutations per the prescribing information)? Y N

   Note: Laboratory documentation must be submitted.

   [If no, then no further questions.]

10. Is the member at least 12 years of age? Y N

    [If no, then no further questions.]

11. Is the requested drug prescribed by, or in consultation with, a pulmonologist? Y N

[If no, then no further questions.]

12. Does the member meet all of the following; A) transaminase (alanine transaminase [ALT], aspartate transaminase [AST]) are monitored at baseline, B) liver function tests have been evaluated, and C) the prescribed dose has been reduced if the member has moderate to severe hepatic impairment? Y N

    [If no, then no further questions.]

13. Is the member taking a moderate to strong Cytochrome P450, family 3, subfamily A (CYP3A) inhibitor(s) (for example, fluconazole, erythromycin, ketoconazole, itraconazole, posaconazole, voriconazole, telithromycin, and clarithromycin)? Y N

    [If no, then no further questions.]

14. Will the member be receiving Symdeko at a decreased dose? Y N

Comments:

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

Prescriber (Or Authorized) Signature **Date**