Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Symdeko
(tezacaftor/ivacaftor)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Symdeko 50mg-75mg/75mg ☐ Symdeko 100mg-150mg/150mg

Directions for use: Duration of therapy: ICD10:
(if more than 2 tablets per day) Please provide clinical support for requesting this dosing/quantity for your patient (examples could include past doses tried, past medications tried, pertinent patient history, etc).

Is this for a new start or continued therapy with Symdeko? ☐ new start ☐ continued therapy

Prior to starting the requested medication, which best described your patient?
☐ previously asymptomatic, or have mild clinical manifestations
☐ measurable lung disease or end organ involvement
☐ unknown

(if previously asymptomatic or mild manifestations) Has your patient had any clinical decline? Please provide supportive documentation. ☐ Yes ☐ No
(if measurable lung disease or end organ involvemnt) Has there been documented clinical response (for example, improvement in FEV1, reduced number of pulmonary exacerbations, improvement in body mass index [BMI] or improvement on the patient reported Cystic Fibrosis Questionnaire-Revised respiratory domain score)? Please provide supportive documentation. ☐ Yes ☐ No

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:
☐ Cystic Fibrosis**
☐ cystic fibrosis transmembrane conductance regulator (CFTR)-related disorder (for example, congenital absence of the vas deferens (CAVD), isolated pancreatitis, recurrent sinusitis or bronchitis)
☐ cystic fibrosis transmembrane conductance regulator (CFTR)-related metabolic syndrome, CF Screen Positive, Inconclusive Diagnosis (CRMS/CFSPID)
☐ Other (please specify)
**submit clinical notes and lab results confirming the standard CF diagnostic criteria

Clinical Information:

*****This drug requires supportive documentation (chart notes, lab and test results, etc). Supportive documentation for all answers must be attached with this request*****

Attach CFTR gene testing confirming the presence of any of the following mutations:

A1067T, A455E
D110E, D110H, D1152H, D1270N, D579G
E193K, E56K, E831X

F1052V, F1074L, F508del
K1060T, L206W, P67L
R1070W, R117C, R347H, R352Q, R74W
S945L, S977F
711+3A→G, 2789+5G→A, 3272-26A→G, 3849+10kbC→T

Is there documentation that your patient has two copies of the F508del mutation (homozygous) in the CFTR gene? ☐ Yes ☐ No

(if no) Is there documentation that your patient has at least ONE mutation that is responsive to tezacaftor/ivacaftor (Symdeko) as specified in the FDA product label: 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 mutation? ☐ Yes ☐ No

Will the requested drug be used in combination therapy with Kalydeco (ivacaftor), Orkambi (lumacaftor/ivacaftor), or Trikafta (elexacaftor/tezacaftor/ivacaftor)? ☐ Yes ☐ No

Additional pertinent information: (*please include clinical reasons for drug, relevant lab values, etc.)*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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