Prescriber Criteria Form Symdeko 2026 PA Fax 2515-A v1 010126.docx Symdeko (tezacaftor/ivacaftor) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Symdeko (tezacaftor/ivacaftor).

Drug Name: Symdeko (tezacaftor/ivacaftor)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of cystic fibrosis? [If no, then no further questions.]	Yes	No
2	Does the patient have the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene? [If no, then skip to question 4.]	Yes	No
3	Is the patient positive for the F508del mutation on both alleles of the cystic fibrosis transmembrane conductance regulator (CFTR) gene? [If yes, then skip to question 5.]	Yes	No
4	Does the patient have a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor potentiation based on clinical and/or in vitro assay data? [Note: Refer to the package insert for full list of responsive mutations.] [If no, then no further questions.]	Yes	No
5	Will the requested medication be used in combination with other CFTR (cystic fibrosis transmembrane conductance regulator) potentiating agents (e.g., ivacaftor, deutivacaftor)? [If yes, then no further questions.]	Yes	No
6	Is the patient 6 years of age or older?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____