

POLICY NAME	Symdeko (tezacaftor-ivacaftor)	POLICY #	2640P
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Criteria

Coverage Criteria

- ☐ 1.1 Documented diagnosis of cystic fibrosis with
- ☐ 1.2 Documentation that member is homozygous for the F508del mutation OR member has at least one mutation in the CFTR gene that is responsive to Symdeko
- ☐ 1.3 Age 6 years of age or older
- ☐ 1.4 Prescribed by a provider specializing in the treatment of cystic fibrosis
- ☐ 1.5 Review of chart notes documenting diagnosis and confirming that patient has met all of the above requirements for treatment with Symdeko by both a pharmacist and medical director