Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Commercial (Traditional)** ☐ **Commercial (Individual/Optimized)** ☒ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Cayston® (aztreonam)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Cayston 75mg powder for inhalation

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Precertification Requirements – *The following information is required for authorization of Cayston:*

Patient must meet all of the following criteria:

1. Patient must have Cystic Fibrosis confirmed by appropriate diagnostic or genetic testing.
2. Patient must be using bronchodilators which are administered prior to aztreonam.
3. Confirmation of ***Pseudomonas aeruginosa*** in cultures of the airways confirmed by a copy of positive sputum culture.
   - Susceptibility results showing aztreonam is the only inhaled antibiotic to which the *Pseudomonas aeruginosa* is sensitive OR
   - At least one of the following:
     - Previous use of tobramycin inhalation solution and experienced a clinically significant adverse drug reaction or unsatisfactory therapeutic response
     - Contraindication/intolerance to tobramycin inhalation solution
     - Culture shows resistance to tobramycin
   - Confirmation that member is not receiving treatment with other inhaled/nebulized antibiotics or inhaled/nebulized anti-infective agents.
4. Age 7 years or older

Duration of Approval: Used 28 days, following 28 days off. **Initial authorization:** 6 months

For continuation, patient must have met the following requirements:

1. Continues to require treatment of Pseudomonas aeruginosa infection
2. Documentation of stabilization or improvement by pulmonologist or CF specialist.

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 02/2018

Last reviewed 07/2018

New request
Priority Health Precertification Documentation

A. Cystic Fibrosis confirmed by appropriate diagnostic or genetic testing?

- ☐ Yes
- ☐ No
- ☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. Pseudomonas aeruginosa on sputum culture sensitive only to aztreonam (please attach C/S)?

- ☐ Yes
- ☐ No

If no, has the patient had a trial with tobramycin inhaled solution?

- ☐ Yes
- ☐ No
  - ☐ Trial and failure or intolerance of tobramycin inhaled solution
  - ☐ Contraindication to tobramycin inhaled solution
  - ☐ Resistance to tobramycin inhaled solution

Rationale for use: _____

C. Patient will not be receiving treatment with other inhaled/nebulized anti-infectives, including alternating treatment schedules or rotation with tobramycin?

- ☐ Yes
- ☐ No

Continuation
Priority Health Precertification Documentation

A. Pseudomonas aeruginosa on sputum culture sensitive only to aztreonam (please attach C/S)?

- ☐ Yes
- ☐ No

Rationale for use: _____

B. Patient condition is stabilized or improved as evaluated by pulmonologist or CF specialist?

- ☐ Yes
- ☐ No

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