PriorityHealth

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

Before this drug is covered, the patient must meet all of the following requirements:

1. Patient must have cystic fibrosis (documentation of a cystic fibrosis ICD10 code* within the last 12 months must be submitted to Priority Health)
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

*Approved ICD10 codes are provided in the Additional Information section

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.

All fields must be complete and legible for review. Your office will receive a response via fax.

No changes made since 09/2016
Last reviewed 07/2018

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.

New request
Priority Health Precertification Documentation

A. What is the patient's diagnosis?

- ☐ Cystic fibrosis (documentation of a cystic fibrosis ICD10 code from within the last 12 months must be submitted to Priority Health)
- ☐ *Other:* ________________

Rationale for use: ________________

B. Are 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 -
  - ☐ Patient had trial and failure or intolerance of tobramycin inhaled solution
  - ☐ Patient has contraindication to tobramycin inhaled solution
  - ☐ Patient has resistance to tobramycin inhaled solution

  Rationale for use: ________________

C. Will patient be receiving treatment with other inhaled/nebulized anti-infectives, including alternating treatment schedules or rotation with tobramycin?

- ☐ Yes
- ☐ No

Request to continue a previously authorized approval
Priority Health Precertification Documentation

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

- ☐ Yes
- ☐ No -*Rationale for use:* ________________

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

- ☐ Yes
- ☐ No

Additional information

Approved ICD10 Codes for Cystic Fibrosis

ICD10	ICD10 Label
E84.0	Cystic fibrosis with pulmonary manifestations
E84.11	Meconium ileus in cystic fibrosis
E84.19	Cystic fibrosis with other intestinal manifestations
E84.8	Cystic fibrosis with other manifestations
E84.9	Cystic fibrosis, unspecified

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