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 – *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

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 07/2018

Last reviewed 07/2020

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, dosing, or a route of administration 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 appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

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. 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: _____

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

- ☐ Yes
- ☐ No

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