

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.

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