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.

TOBI® Podhaler™ (tobramycin inhalation powder)

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

Drug product: ☐ TOBI Podhaler 28 mg per capsule

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. Must be used for cystic fibrosis
2. Must have suspected or confirmed diagnosis of *Pseudomonas aeruginosa* lung infection
3. Must first have a trial and clinical failure on tobramycin inhalation solution (generic TOBI)
4. Must be age 6 years or older
5. When authorized, must not exceed a 28-day supply every 56 days (28 days on and 28 days off)

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Cystic fibrosis

☐ *Other – the patient's condition is:* ______________________

Rationale for use: ______________________

B. Did the patient first try tobramycin inhalation solution (generic TOBI)?

☐ Yes ☐ No

C. Does that patient have suspected or confirmed diagnosis of *Pseudomonas aeruginosa* lung infection?

☐ Yes

☐ No, *rationale*: ______________________

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

Updated 02/2018
Last reviewed 11/2018