

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

New request Continuation request

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: _____