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.

Tobramycin (generic TOBI®) / Kitabis Pak® / Bethkis®

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:

☐ Tobramycin 300 mg/5 mL ampul-neb

☐ Kitabis Pak 300 mg/5 mL

☐ Bethkis 300mg/4mL

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 be age 6 years or older
4. When authorized, must not exceed a 28-day supply every 56 days (28 days on and 28 days off)

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.

Priority Health Precertification Documentation

What condition is this drug being requested for?

☐ Cystic fibrosis

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

Rationale for use: _____

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