

Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS (MEDICAID)

Inhaled Antibiotics for CF (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.

Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-855-684-5250**.

When conditions are met, we will authorize the coverage of Inhaled Antibiotics for CF (Medicaid).

Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Tobramycin inhalation solution Tobi Podhaler (tobramycin inhalation powder)

Bethkis (tobramycin inhalation solution) Kitabis (tobramycin inhalation solution)

Cayston (aztreonam)

Other, please specify _____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Does the patient have a diagnosis of cystic fibrosis? Y N

[If no, then no further questions.]

2. Were sputum cultures positive for *P. aeruginosa*? Y N

[If no, then no further questions.]

3. Is the patient colonized with *Burkholderia cepacia*? Y N

[If yes, then no further questions.]

4. Is this request for Cayston? Y N

[If yes, skip to question 7.]

5. Does the patient have an FEV1 between 25-80% predicted? Y N

[If no, then no further questions.]

6. Is this request for Tobi Podhaler or Bethkis? Y N

[If yes, skip to question 9.]

[If no, skip to question 10.]

7. Does the patient have an FEV1 between 25-75% predicted? Y N

[If no, then no further questions.]

8. Do sputum cultures show resistance to tobramycin? Y N

[If yes, skip to question 10.]

9. Has the patient had an inadequate response or intolerable side effects with generic tobramycin nebulizer solution? Y N

[If no, then no further questions.]

10. Is the patient's age within the FDA labeling for the requested product (FDA approved age is 6 years and older for tobramycin products and 7 years and older for Cayston)? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature

Date