Tobramycin

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: ______________________________ **Date**: _________________________________
Patient's ID: ________________________________ **Patient's Date of Birth:** ________________
Physician's Name: ____
Specialty: __________________________________ **NPI#:** _________________________________
Physician Office Telephone: __________________ **Physician Office Fax:** ___________________
Request Initiated For: _______________________

1. What medication is being prescribed?
   ❑ tobramycin inhalation solution (generic)
   ❑ Bethkis
   ❑ TOBI
   ❑ TOBI Podhaler
   ❑ Kitabis Pak
   ❑ Other ___________________________________

2. What is the diagnosis?
   ❑ Cystic fibrosis
   ❑ Bronchiectasis
   ❑ Other ____

3. What is the ICD-10 code? _______________

Complete the following questions if brand TOBI or TOBI Podhaler are being prescribed. If not, skip to #7.

4. *If brand TOBI or TOBI Podhaler are being prescribed,* the preferred products for your patient's health plan are generic tobramycin inhalation solution and Bethkis. Can the patient's treatment be switched to one of the preferred products?
   ❑ Yes ❑ No *If Yes, specify drug, fax a new prescription to pharmacy and skip to #7:* ___________________
   ❑ Not applicable - brand TOBI or TOBI Podhaler are NOT being prescribed, *skip to #7.*

5. Has the patient experienced a documented intolerable adverse event to BOTH of the preferred products (i.e., generic tobramycin inhalation solution and Bethkis)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No

6. Was the intolerable adverse event an expected adverse event attributed to the active ingredient (i.e., tobramycin) as described in the prescribing information (i.e., known adverse reaction for both the preferred and requested tobramycin inhalation product)? ❑ Yes ❑ No

7. Is the patient currently receiving therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #9*

8. Is the patient experiencing a benefit from therapy with the requested medication as evidenced by disease stability or disease improvement? ❑ Yes ❑ No *No further questions*

9. Is *Pseudomonas aeruginosa* present in airway cultures? *If Yes, no further questions.* ❑ Yes ❑ No

10. Does the patient have a history of *Pseudomonas aeruginosa* infection or colonization in the airways?
❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

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CVS Caremark Prior Authorization ● 1300 E. Campbell Road ● Richardson, TX 75081

Phone: 1-866-814-5506 ● Fax: 1-866-249-6155 ● www.caremark.com